1986 MEDICARE BUDGET ISSUES

HEARINGS

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON WAYS AND MEANS
HOUSE OF REPRESENTATIVES

NINETY-NINTH CONGRESS

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1986 MEDICARE BUDGET ISSUES

MONDAY, APRIL 1, 1985

House of Representatives,
Committee on Ways and Means,
Subcommittee on Health,
Washington, DC.

The subcommittee met, pursuant to notice, at 2:10 p.m., in room 1100, Longworth House Office Building, Hon. Fortney H. (Pete) Stark (chairman of the subcommittee) presiding.

[Press releases announcing the hearings and background material follow:]

[For immediate release, Wednesday, Mar. 27, 1985]

The Honorable Fortney H. (Pete) Stark (D., Calif.), Chairman, Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives, Announces Hearings on 1986 Medicare Budget Issues To Be Held on Monday, April 1, and Monday, April 15, 1985

The Honorable Fortney H. (Pete) Stark (D., Calif.), Chairman of the Subcommittee on Health of the Committee on Ways and Means, U.S. House of Representatives, today announced that the Subcommittee on Health will hold hearings on the proposed medicare budget on Monday, April 1 and Monday, April 15, 1985. The April 1 hearing will begin at 2 p.m., and the April 15 hearing will begin at 10 a.m. Both days' hearings will be held in the Committee's main hearing room, 1100 Longworth Building.

The hearings will focus on changes recommended by the Reagan Administration that are estimated to reduce medicare expenditures by more than $41 billion over the next five years. The major proposals involved would freeze payments to hospitals, extend the freeze on physician fees and require beneficiaries to pay more out of pocket for medicare covered services. Whether any of these proposals is necessary or desirable will be examined in the light of how medicare providers and beneficiaries have been impacted by major reimbursement changes adopted in recent years.

Oral testimony will be heard from invited witnesses only. However, any individual or organization may submit a written statement for consideration by the Subcommittee and for inclusion in the printed record of the hearing.

Administration witnesses, who will appear on Monday, April 1, will be asked to assess implementation of the recent hospital, physician and other reimbursement changes as well as to report on the status of several studies and reports on aspects of these changes that the law requires the Administration to submit to the Congress. Among these reports is one relating to an adjustment of medicare payments for hospitals with a disproportionate share of low-income patients.

BACKGROUND

The President's budget for fiscal year 1986 recommends a number of significant changes. These include: freezing payment rates to hospitals; freezing payments for direct medical education at current levels; reducing by 50% payments for indirect medical education; continuing for another year the freeze in physician payment rates; delaying the start of medicare coverage to first of month following 65th birthday; making medicare the secondary payer for working beneficiaries over 69; increasing the part B premium rate for supplementary medical insurance; and requiring patient copayments for some home health visits.

In order to assure the most productive use of the limited amount of time available to question witnesses, witnesses invited to appear before the Subcommittee are asked to comply with the following requirements:

1. At least two full days before their scheduled appearance, all witnesses should submit 10 copies of their prepared statements to the Main Committee Office, Room 1102 Longworth House Office Building, and should provide at least 75 copies early on the morning of the hearing.

2. Each statement to be presented to the Subcommittee or any written statement submitted for the record should contain the following information:

a. The name, full address, and capacity in which the witness will appear (as well as a telephone number where the witness or a designated representative may be reached);

b. A list of any clients or persons, or any organization for whom the witness appears; and

c. A topical outline or summary of comments and recommendations.

3. Witnesses should not read their written statements to the Subcommittee, but should instead limit their oral presentations to a summary of the points included in the statement. Witnesses are requested to limit their oral summaries to no more than five minutes.

WRITTEN STATEMENTS IN LIEU PERSONAL APPEARANCE

For those who wish to file a written statement for the printed record of the hearing, six copies are required and may be submitted by the close of business on Tuesday, April 30, 1985, to Joseph K. Dowley, Chief Counsel, Committee on Ways and Means, U.S. House of Representatives, Room 1102 Longworth House Office Building, Washington, DC 20515. An additional supply of statements for the printed record may be furnished for distribution to the press and public if supplied to the Committee office before the hearing scheduled for April 15 begins.

[For immediate release Thursday, Apr. 4, 1985]

THE HONORABLE FORTNEY H. (PETE) STARK (D., CALIF.), CHAIRMAN, SUBCOMMITTEE ON HEALTH, COMMITTEE ON WAYS AND MEANS, U.S. HOUSE OF REPRESENTATIVES, ANNOUNCES A CHANGE OF TIME AND ADDED DATE FOR HEARINGS ON MEDICARE BUDGET ISSUES

The Honorable Fortney H. (Pete) Stark (D., Calif.), Chairman of the Subcommittee of Health of the Committee on Ways and Means, U.S. House of Representatives, today announced a change in starting time for the hearing scheduled for April 15, 1985. He also announced that an additional day of testimony from invited witnesses on medicare budget issues will be held the following day, April 16.

The April 15 hearing will begin at 1:00 p.m. in the main Ways and Means Committee hearing room, 1100 Longworth House Office Building. The April 16 hearing will begin at 9:30 a.m. in Room B-318 in the Rayburn House Office Building.

The focus and scope of the hearing are described in Health Subcommittee press release #2, issued March 27. All other details concerning the hearing remain the same.

BACKGROUND MATERIAL

FY 86 ADMINISTRATION BUDGET PROPOSALS

(1) FREEZE HOSPITAL DRG PROSPECTIVE PAYMENT RATES

The Secretary, taking into account the recommendations of the Prospective Payment Assessment Commission, has the authority to increase annually the DRG payment rates but not to exceed the increase in the hospital market-basket (the price of goods and services used by hospitals) plus one-quarter of one percentage point in FY 1986.

Proposal: The Administration proposes, by regulation, to freeze medicare's DRG payment rates to hospitals at the FY 1985 levels.

(2) 50% REDUCTION IN THE INDIRECT TEACHING ADJUSTMENT

Under the prospective payment system (PPS), hospitals receive an additional payment to compensate them for indirect cost associated with a teaching program.

Proposal: The Administration recommends reducing this payment by half.

(3) FREEZE PAYMENTS FOR DIRECT MEDICAL EDUCATION

Direct costs of approved medical education programs are excluded from PPS and are paid on the basis of reasonable costs.

Proposal: The Administration proposes, by regulation, to permanently freeze reimbursement for such costs at the level not to exceed that received by the hospital in its cost reporting period ending in FY 1984.

(4) FREEZE PAYMENT FOR PPS EXEMPT HOSPITALS

Hospitals that are exempt from PPS, (e.g. psychiatric, rehabilitation, and long-term care) are paid on the basis of historical cost in a base year subject to a specified rate of increase.

Proposal: The Administration proposes, by regulation, to freeze the payment rates for exempt hospitals at the FY 1985 levels.

(5) RESTRUCTURE HOME HEALTH LIMITS

Home health services are currently reimbursed on a cost basis, not to exceed the 75th percentile of the costs per visit incurred by all home health agencies. Separate limits are established for each type of visit, yet they are applied in the aggregate to each agency based on its mix of services.

Proposal: The Administration proposes, by regulation, to revise the calculation of the limits.

(6) FREEZE LIMITS OF SKILLED NURSING FACILITIES

Reimbursement to skilled nursing facilities (SNFs) is subject to specified cost limits. The limits are adjusted annually to reflect the SNF market-basket index.

Proposal: The Administration proposes, by regulation, to freeze the SNF limits for accounting years beginning on or after July 1, 1985, at the preceding year's level.

(7) FREEZE PAYMENTS FOR DURABLE MEDICAL EQUIPMENT (DME)

Payments for durable medical equipment are on the basis of reasonable charges when furnished by a supplier.

Proposal: The Administration proposes, by regulation, to freeze customary and prevailing charges for DME and related items for one year. Thereafter, prevailing charges would be indexed to the CPI.

(8) FREEZE CLINICAL LAB FEE SCHEDULE

The Deficit Reduction Act established a fee schedule for clinical laboratory services for ambulatory patients, adjusted annually to reflect changes in the CPI.

Proposal: The Administration recommends freezing the fee schedule amounts for one year.

(9) EXTEND FREEZE ON PHYSICIAN FEES FOR 1 YEAR

The Deficit Reduction Act of 1984 froze physicians' fees for 15-months, (July 1, 1984–September 30, 1985). It also established participating physician arrangements. As an incentive for participation, participating physicians were permitted to raise their charges during the freeze period in order to have such charges reflected in the customary charges recognized by medicare during FY 1986. Non-participating physicians were prohibited from increasing their actual charges to medicare beneficiaries over their charges in a base period (April 1, 1984—June 30, 1984).

Proposal: The Administration recommends extending this freeze for an additional year. Participating physicians would not get the October 1, 1985 medicare fee update promised them. Non-participating physicians would be prohibited from increasing their charges over the base period (April 1, 1984–June 30, 1984) levels.

(10) DELAY INITIAL ELIGIBILITY FOR MEDICARE BY 1 MONTH

Eligibility for medicare begins on the first day of the month in which an individual reaches age 65.

Proposal: The Administration recommends delaying initial medicare eligibility to the first day of the month following the month in which an individual reaches age 65.

(11) INDEX PART B DEDUCTIBLE TO ECONOMIC INDEX

The current part B deductible is $75 each year.

Proposal: The Administration recommends indexing the part B deductible to the medicare economic index rounded to the next highest dollar. The part B deductible would be: 1987—$78; 1988—$82; 1989—$86; 1990—$90.

(12) REQUIRE HOME HEALTH COPAYMENTS

Home health services are covered with no out of pocket payment by beneficiaries.

Proposal: The Administration recommends establishing a copayment amount equal to one percent of the inpatient hospital deductible on visits after the 20th visit ($4.80 a visit in 1986).

(13) INCREASE PART B PREMIUM TO 35 PERCENT OF PROGRAM COSTS BY 1990

Currently, the part B premium is set to cover 25 percent of the costs of the part B program.

Proposal: The Administration proposes, by legislation, to gradually increase the part B premium over five years so that it would equal 35 percent of the estimated cost of part B program for age enrollees.

[Estimated premiums]

	Current law	Proposed law
1986	$16.10	$16.80
1987	18.70	21.00
1988	19.50	24.90
1989	20.30	29.10
1990	21.10	34.00

(14) EXTEND THE WORKING AGED POLICY

Currently, employers must offer employees aged 65-69, (or their spouses) the same group health plan offered to younger employees. If the beneficiary (or spouse) elects such plan, medicare becomes secondary payer.

Proposal: The Administration recommends extending this provision to employees (or spouses) over age 69.

(15) OPTIONAL MEDICARE VOUCHERS

For the most part, medicare payments are made on behalf of beneficiaries to hospitals and other institutions and to, or on behalf of, beneficiaries for physican and other medical services. However, an HMO meeting specified requirements can elect to receive a fixed medicare payment (like a voucher) to provide medicare services to beneficiaries enrolled in the HMO.

Proposal: The Administration recommends establishing a voluntary medicare voucher program under which private health benefits plans could enroll medicare beneficiaries and provide medicare coverage for a fixed payment from the medicare program.

(16) MISCELLANEOUS PROPOSALS

The Administration recommends simplifying part A bill processing and eliminating the separate fiscal intermediary for the Railroad Retirement Board.

[Dollars in millions]

	Fiscal year—					5-year total
	1986	1987	1988	1989	1990	
Hospital reimbursement reductions:						
Freeze fiscal year 1986 hospital DRG payment rates at fiscal year 1985 level (includes waivered States) [1]	−$1,530	−$2,195	−$2,665	−$3,135	−$3,675	−$13,200
50 percent reduction in indirect teaching costs adjustment	−590	−810	−1,100	−1,230	−1,360	−5,090
Freeze payments for direct medical education [1]	−130	−280	−460	−650	−870	−2,390
Freeze payments to PPS exempt hospitals [1]	−40	−55	−60	−70	−75	−300
Other provider reductions:						
Restructure limits on home health payments [1]	−0	−0	−0	−0	−0	−0
Freeze limits on payments for skilled nursing facilities [1]	−3	−5	−5	−5	−10	−28
Freeze customary and prevailing charges for durable medical equipment [1]	−55	−100	−140	−190	−255	−740
Premium offset	10	20	20	25	30	105
Freeze clinical lab fee schedule	−50	−80	−235	−400	−530	−1,295
Premium offset	5	15	35	55	60	170
Physician payment reductions:						
Extend physician freeze for 1 year; prohibit increases in actual charges for nonparticipating physicians	−475	−450	−450	−475	−475	−2,325
Premium offset	70	85	70	65	55	345
Beneficiary related cuts:						
Delay initial eligibility for medicare by 1 full month	−245	−270	−295	−330	−365	−1,505
Premium offset	45	60	70	80	95	350
Index part B deductible to economic index		−75	−190	−240	−330	−835
Premium offset	0	15	30	30	40	115
Require copayment for home health visits after 20 have been provided ($4.80 in 1986)	−65	−120	−130	−150	−160	−625
Increase the part B premium to 35 percent of program costs by 1990 (increased revenues) [2]	−211	−714	−1,743	−3,205	−4,947	−10,820
Other proposals:						
Extend the medicare working aged provision to employees over age 69	−230	−360	−400	−460	−520	1,970
Premium offset	5	15	15	15	15	65
Optional medicare vouchers		1	1	1	1	1
Misc. proposals (simplify processing of part A claims; eliminate separate carrier for RRB)	−5	−6	−6	−6	−7	−30
Regulatory	−1,748	−2,615	−3,310	−4,025	−4,855	−16,553
Legislative	−1,746	−2,694	−4,328	−6,250	−8,428	−23,446
Total Medicare savings	−3,494	−5,309	−7,638	−10,275	−13,283	−39,999

[1] Regulatory initiative. Premium Offsets are the change in premium income resulting from a given proposal assuming current law premium policy.
[2] Table follows:

	Premiums	
	Current law	Proposed law
1986	$16.10	$16.80
1987	18.70	21.00
1988	19.50	24.90
1989	20.30	29.10
1990	21.10	34.00

Chairman **Stark**. The House Subcommittee on Health will begin. This hearing today will be on the Medicare budget for fiscal year 1986. We are particularly worried about how much we must spend and how much we will be able to spend to provide the citizens with the quality of medical care they have come to rely on.

The Medicare Program deals with a number of complex issues. These hearings will focus on a single key question: How much additional payment providers will require during the coming fiscal year to maintain today's level of service?

In the hospital area, the parameters are clear: the freeze that HHS is recommending at one level—that's the zero baseline, if you will—and the higher payment that would be due under the normal inflation adjustment process at the other, which would be an approximately 6-percent increase. In between—ProPAC has suggested for the hospital at least a 2½-percent increase.

Generally, the administration proposal is at one end of the spectrum and the investment in current law is at the other. It is generally within the range of zero to 6 percent.

We are dealing with a complex subject, and at this hearing of the subcommittee we will do our best to keep it as understandable as possible.

To that end, we ask all witnesses, to the last witness at the continuation of this hearing later this month: confine your remarks to evaluating the specific proposals made by the administration rather than suggesting revised policies of your own. I point out the example of the Chair, who has had a bill for a number of years to increase tax for cigarettes and to dedicate that tax to Medicare. That would be out of order—and I will so rule. That is not the discussion today. That is a topic which we may have hearings on in the future, but the point is if we are going to get some idea of the critical impact of these budget proposals, we are all going to have to cooperate to deal with the 1986 rules and procedures, and what would happen if we adjust that in effect downward, the anticipation of 60 percent.

We don't want to feed our hospitals to the point where they become obese; while we want them to be lean, we wouldn't want them to starve.

How will you function—those people who will be invited later, providers—how will they function during fiscal year 1985, and what they would have to do to adjust under the diet that Dr. Davis is going to propose, or ProPAC would propose or whether they will be allowed to continue their old habits.

I really don't anticipate that we will have a debate on the quality of care. The reason that's off the table is because we can presume that everyone in this room—members, members of the administration, staff, visitors—is unwaiveringly committed to the quality of care. That, basically, is not an issue before us. We never have enough resources to provide the quality of care to all who want it. We are dealing with sets of priorities that the real world forces upon us.

Unfortunately, we will not be able to hear all the people who want to testify, but we solicit testimony from those who are interested in the continuation of these hearings. It will be made a part of the record, and we will consider them carefully as we debate the Medicare provisions in the budget arena in subsequent weeks.

Mr. Gradison.

Mr. GRADISON. Mr. Chairman, I certainly concur in the framework that you have set for these hearings. I do think, however, that there are some related issues that we should be inquiring into relating to concerns of quality—disproportionate share, intercity impact—factors of that kind.

But I think these will naturally flow from the guidelines which you have set down here.

Chairman STARK. Our witness today is the administrator of the Health Care Financing Administration, Dr. Carolyne K. Davis.

Dr. Davis, we have a copy of your written statement. You may proceed to summarize that, or however you wish to proceed.

STATEMENT OF CAROLYNE K. DAVIS, PH.D., ADMINISTRATOR, HEALTH CARE FINANCING ADMINISTRATION, DEPARTMENT OF HEALTH AND HUMAN SERVICES, ACCOMPANIED BY JAMES SCOTT, ACTING DEPUTY ADMINISTRATOR, AND CAROL KELLY, ACTING ASSOCIATE ADMINISTRATOR

Ms. DAVIS. Thank you, Mr. Chairman. I am very pleased to be here today to discuss our Medicare proposals. I would like to introduce the people who are accompanying me. To my left is James Scott, the Acting Deputy Administrator, and to my right is Carol Kelly, who is Acting Associate Administrator for Policy.

Our 1986 budget reflects the administration's commitment to halt the increased spending in Medicare in order to reduce the Federal deficit and to strengthen the overall financial integrity of the program.

I think it's important to look back and reflect that when this administration took office, Medicare costs were rising then at 19 percent a year; in this past year that growth has declined to 6 percent. We believe that we must continue to hold the line on health care costs as an integral part of the Governmentwide effort to limit our Federal spending and yet continue to carry out the important mission of our programs, because indeed our mission is important.

Almost 13 percent of the people in America are covered by the program—that means roughly 31 million individuals.

I think it's important to reflect that with our total Medicare proposals for 1986, expenditures would increase from $71.8 billion to $73.3 billion in that fiscal year. Our legislative and regulatory proposals would save approximately $4.2 billion with a 5-year savings of $44 billion over what they would have been if our proposals were not enacted. Most of those savings, in fact the largest part of them, some 79 percent, would come from changes that affect health care providers. Another 12 percent would be from changes affecting the private sector. And only 9 percent would be coming from changes directly affecting beneficiaries.

To highlight the specific proposals, I will group them into three general categories: cost savers, program reform, and cost sharing.

The cost savers generally will maintain existing payment levels for 1 year. The major cost-saving proposals include:

First, maintaining the prospective payment rates for hospitals at the fiscal year 1985 level for 1 year, beginning October 1, 1985—in other words, for fiscal year 1986.

The system has clearly begun to work well under prospective payment—I think it was implemented rather smoothly, with about 81 percent of all hospitals, roughly 5,400, participating now. I think that implementation has proceeded very smoothly, largely as a tribute to the cooperative efforts between the hospitals and the intermediaries and the Government. Of course, the most recent implementation of the Peer Review Organization System has served to assure the commitment that quality care and access to that care are being maintained for the beneficiaries.

Our initial feedback on the impact of prospective payment indicates that the hospitals are indeed responding by becoming more efficient. The length of stay has dropped significantly, thereby reducing the cost for routine services. We know, too, that productivity for the Nation has increased 3 percent and therefore we think it's reasonable to assume that the incentives of the prospective payment system would presumably lead to increases in productivity in the hospital industry as well.

In addition, the new economic forecasts show the hospital marketbasket for 1985 to be less than what was projected when the initial 1985 rates were established.

So for all those reasons and on the basis of recent reports on the increased profit margins in hospitals, we believe that the current rates will indeed be adequate for an additional year. I would like to point out that the proposal to pay at the 1985 rates will save approximately $1.8 million in 1986 and about $12.7 million over the next 5 years.

Second, the second component that I would speak about is freezing the payment for direct medical education and eliminating the doubling of the payment for indirect medical education.

In fiscal year 1986, in order to control the open-ended payments for the direct medical education expenses, which right now are a passthrough, we would freeze the reimbursement levels at a base accounting year level. And that would provide hospitals with an incentive to contain the cost of those programs and to curtail the training of surplus professionals.

We also reimburse teaching hospitals an additional amount associated with medical education, and we normally refer to that as the indirect payments. We are proposing to eliminate the doubling of the payment for indirect medical education which was mandated by Congress in the initial prospective payment legislation. We have no empirical evidence that paying the hospitals twice the amount calculated for the indirect cost of medical education is actually necessary.

Third, we are also proposing to extend the freeze on physician reimbursement for 1 year. Under our proposal, the freeze on physician fees would be extended through September 30, 1986.

The participating physician provision became effective last October. We had approximately 30 percent of the physicians and 24 percent of the suppliers who signed agreements to accept assignment for all Medicare services.

During the last quarter of 1984, we found that 64 percent of all of the payments were made to suppliers and physicians on the basis of assignment on a claim-by-claim basis. That represents a 14-percent increase over the same period in 1983.

We believe that these data demonstrate that the participation program has not adversely affected the beneficiaries' financial protection.

If we do not extend the current freeze, we would expect that Medicare spending for physicians' services would increase by about 12 percent in fiscal year 1986. This part of our budget represents the fastest growing activity in the Federal budget, with only defense and the interest on the national debt growing faster.

The freeze on physicians payments would save approximately $500 million in in 1986 and $2.225 million over 5 years.

Fourth, we are also proposing to maintain the current payment levels for other providers and suppliers of services. This would include payment limits for skilled nursing facilities, the fee schedules for clinical laboratories, reimbursement levels for hospitals and units that are exempt from the prospective payment system, and the customary and prevailing charges for durable medical equipment and the other types of part B services. The method for calculating home health limits would also be revised, and those limits would be applied by type of service rather than in the aggregate.

Under the category of program reform, we propose to extend the concept of Medicare as the secondary payer to the working elderly over age 69 and their spouses who are covered by employer-based group health insurance. Making Medicare the secondary payer would assure that Medicare payments do not subsidize the premiums of employer-based health insurance plans and would avoid Medicare expenditures without an adverse impact on our beneficiaries. That would save, too, approximately $295 million in 1986 and about $2.5 billion over 5 years.

Under the category of beneficiary cost-sharing, we are proposing to:

First, establish a modest copayment of 1 percent of the hospital deductible, which we project to be about $4.80 in 1986, for each home health visit after the twentieth visit in a calendar year.

Since the average number of visits for those who use home health services tends to be about 25 per year, the average using patient would face a copayment of $24. I think it's instructive, too, to recognize that home health care currently is the only major part A service that is provided without a cost-sharing by the beneficiary.

Second, we are also proposing to gradually change the Medicare part B premium by increasing it by 2 percent of the program costs each year over a 5-year time period.

When part B was first enacted, the premium was designed to support half the cost of the benefit. But between 1974 and 1982, the premium was allowed to grow no faster than the Social Security cost-of-living adjustment. By 1982, the premium covered only about 25 percent of the program costs.

This proposal would improve the balance of funding by raising the premium to 35 percent of the cost by 1990. No increase would occur if a paying beneficiary had no increase in a particular year in Social Security benefits.

Third, the final Medicare proposal I will discuss would index the part B deductible, beginning in 1987, to the Medicare economic index. This would restore the economic value of the deductible which in the past has increased infrequently.

In conclusion, I believe our 1986 Medicare proposals are absolutely necessary in order to bring the growth in health care costs more in line with the growth in the other areas of the economy.

Our Medicare proposals build on the success of this administration in reversing the escalation in health care costs which have jeopardized the retirement security of elderly Americans.

I think, with that, Mr. Chairman, I will be pleased to answer any questions you may have.

[The prepared statement follows:]

STATEMENT OF CAROLYNE K. DAVIS, PH.D., ADMINISTRATOR, HEALTH CARE FINANCING ADMINISTRATION, DEPARTMENT OF HEALTH AND HUMAN SERVICES

I am pleased to be with you today to discuss our Medicare proposals for FY 1986. Our 1986 budget reflects the Administration's strong commitment to halt increased spending in Medicare necessary to reduce the Federal deficit and strengthen the overall financial integrity of the program. We see these measures as essential to restore the stability of this program and to assure its continued availability for the elderly and disabled who rely upon Medicare to meet their basic health care needs.

When this administration took office, Medicare costs were rising at 19 percent a year. In the past year that growth has declined to 6 percent. This has been accomplished through reforms that have resulted in an overall decrease in inflation and through specific health care reforms designed to control costs while maintaining access to quality health care for our beneficiaries. In 1986, we must continue to hold the line on health care costs as an integral part of a Government-wide effort to limit Federal spending while carrying out the important mission of our programs.

BACKGROUND ON MEDICARE

As you know, the Medicare program was enacted in 1965 to provide insurance coverage of hospital, physician, and other medical services for our nation's aged. This coverage was extended to disabled individuals in 1973. Almost 13 percent of all the people in the United States, or close to 31 million individuals, are covered by Medicare. This year Medicare will pay the bills for over 20 million beneficiaries.

Under our Medicare proposals for 1986, expenditures would increase from $71.8 billion in 1985 to $73.3 billion in 1986. But our legislative and regulatory proposals would save $4.2 billion in 1986 with five-year savings of $44 billion over what expenditures would be if our proposals were not enacted. By far the largest part of these savings—some 79 percent—would come from changes affecting health care providers. Another 12 percent would come from changes affecting the private sector. Only 9 percent will come from changes directly affecting beneficiaries.

Let me briefly describe our Major Medicare proposals designed to constrain spending and reduce the Federal deficit.

MEDICARE PROPOSALS

Our Medicare proposals fall into three general categories: cost savers, program reform, and cost sharing. The cost savers generally maintain existing payment levels for one year. Major cost-saving proposals include:

Maintaining the prospective payment rates for hospitals at the FY 1985 level for one year beginning October 1, 1985.

We believe that the prospective payment system (PPS) has had a significant influence on the declining growth of health care costs I mentioned earlier. During the year in which the system was implemented, over 5,400 short-term hospitals—81 percent of all hospitals participating in Medicare—were being paid under PPS. The implementation of PPS has proceeded smoothly, thanks in large part to the cooperation of hospitals and our intermediaries. Recent implementation of the Peer Review Organization (PRO) program is serving to reinforce our commitment to assuring that quality care and access to that care are being maintained for our beneficiaries.

However, as with all new programs, PPS has raised some issues which we are working to resolve. Questions still remain concerning separate rates for urban and rural areas. We are making progress in this area and are nearing completion of our study of the area wage index required by the Deficit Reduction Act of 1984 (P.L. 98-369). The study is based on Data we collected which seeks to accurately distinguish between full—and part-time workers. We are also continuing to work on other issues concerning aspects of the PPS that Congress has directed us to address.

Initial feedback on the impact of PPS indicates that hospitals are responding by becoming more efficient. Length-of-stay has dropped significantly, thereby reducing costs for routine services. Productivity for the Nation as a whole has increased 3 percent and it is reasonable to assume that the incentives of PPS should lead to increases in productivity of the hospital industry. In addition, new economic forecasts show the hospital marketbasket for 1985 to be less than was projected when 1985 rates were established. For these reasons and on the basis of recent reports of increased profit margins in hospitals, we believe the current rates will be adequate for an additional year. This proposal would save $1.800 million in FY 1986 and $12,733 million over the next five years.

Freezing the payment for direct medical education and eliminating the doubling of the payment for indirect medical education.

Medicare pays its share of the salaries and associated expenses for training interns and residents in teaching hospitals. These payments are not included under the prospective payment rates. Direct medical education costs are reimbursed on a retrospective cost basis.

In 1986, to control open-ended payments for direct medical education expenses, we would freeze the reimbursement levels for direct medical education at a base accounting year level. This would provide hospitals with an incentive to contain the cost of these programs and to curtail the training of surplus professionals. In addition, this is consistent with the strategy to freeze limits on Medicare payments.

Medicare also reimburses teaching hospitals an additional amount associated with medical education programs. Indirect payments are reimbursed as a percentage add-on to the DRG payment. We are proposing to eliminate the doubling of the payment for indirect medical education mandated by Congress in the original prospective payment legislation. We have no empirical evidence that paying hospitals twice the amount calculated for the indirect cost of medical education is necessary. To the contrary, industry publications have reported that, in the first year under the prospective payment system, most hospitals have increased their profit margins, especially major teaching hospitals.

Freezing the payment for direct medical education would save $150 million in 1986 and $2,710 million over five years. Eliminating the doubling of the payment for indirect medical education would save $695 million in 1986 and $6,595 million over five years.

Extending the freeze on physician reimbursement for one year. Under our proposal, the freeze on physician fees paid by Medicare would be extended through September 30, 1986.

The Deficit Reduction Act of 1984 mandated significant changes in physicians reimbursement, including a 15-month freeze on customary and prevailing charges; the establishment of a participating physician and supplier program; and a freeze on the actual charges of nonparticipating physicians.

The participating physician provision became effective last October with 30 percent of physicians and 24 percent of suppliers signing agreements to accept assignment for all Medicare service provided in FY 1985. Physicians who did not sign agreements remain free to choose for which services they will accept assignment. During the last quarter of 1984, 64 percent of physician and supplier payments were made on the basis of assignment. This represents a 14 percent increase over the same period in 1983 and an 8 percent increase over the previous quarter. We believe that these data demonstrate that the participation program has not affected beneficiary financial protection.

Our carriers have been monitoring the actual charges of nonparticipating physicians to enfore the fee freeze. Data from the last quarter of 1984 show that the vast majority of physicians are complying with the freeze. On average, about 4 percent of nonparticipating physicians have been identified for intensive monitoring. After additional examination, we expect this percentage to decline. The remaining physicians who appear, during intensive monitoring, to be violating the freeze will be referred to the Office of the Inspector General for possible imposition of sanctions.

If the current freeze is not extended, Medicare spending for physicians' services is expected to increase about 12 percent in FY 1986. This represents one of the fastest growing activities in the Federal budget; only defense and interest on the national debt will grow faster.

Savings to Medicare would be $500 million in 1986 and $2,225 million over five years.

Maintaining the current payment levels for other providers and suppliers of services.

This would include the payment limits for skilled nursing facilities, the fee schedules for clinical laboratories, the reimbursement levels for hospitals and units exempt from the prospective payment system, and the customary and prevailing charges for durable medical equipment and other part B servies. The method for calculating home health limits would be revised and the limits would be applied by type of service rather than in the aggregate. Again, this is consistent with the continuation of current payment levels through 1985. Freezing the payment levels for providers and suppliers of services and modifying home health reimbursement would save $180 million in 1986 and $2.980 million over five years.

Under the category of program reform we propose to:

Extend Medicare as the secondary payor to the working elderly over age 69 and their spouses who are covered by employer-based group health insurance. This proposal simply conforms treatment of older working beneficiaries and spouses with that of workers and covered spouses under age 70. Making Medicare the secondary payor would assure that Medicare payments do not subsidize the premiums of employer-based health insurance plans and would avoid Medicare expenditures without adverse effects to beneficiaries. This will save $295 million in 1986 and $2.5 billion over five years.

Under the category of beneficiary cost-sharing we propose to:

Establish a modest copayment of one percent of the hospital deductible (projected to be about $4.80 in 1986) for each home health visit after the 20th visit in a calendar year.

Since the average number of visits for those who use home health care is about 25 per year, the average using patient would face copayments of $24 in 1986. This modest out-of-pocket beneficiary contribution will help stem the 18 percent annual growth in home health costs. Enactment of a copayment would conform home health to hospital and nursing home benefits. Currently home health care is the only major part A service provided without an cost-sharing by the beneficiary.

A 1981 General Accounting Office study found that about 25 percent of visits for which claims had been made were medically unnecessary or noncovered. A recent HCFA study of home health care claims resulted in similar findings. This proposal would encourage more appropriate utilization of home health services.

Gradually change the Medicare part B premium by increasing it by 2 percent of program costs each year over a five-year period.

When part B was first enacted, the premium was designed to support half the cost of the benefit. However, between 1974 and 1982, the premium was allowed to grow no faster than the Social Security cost-of-living adjustment. By 1982, the premium covered only about 25 percent of program costs. This proposal would improve the balance of funding by raising the premium to 35 percent of costs by 1990. No increase would occur if a paying beneficiary had no increase in a particular year in Social Security benefits; thus no recipient of Social Security benefits would suffer an actual reduction in the net retirement, survivors or disability amount after deduction of the part B premium. The monthly part B premium for 1986 would be $16.80, just 70 cents over what it would be under current law.

The final Medicare proposal I will discuss today would index the part B deductible, beginning in 1987 to the Medicare Economic Index. This would restore the economic value of the deductible which, in the past, has increased infrequently. For example, in 1982 the deductible was increased from $60 to $75, the first increase since 1972 despite a more than 500 percent increase in expenditures. This proposal would increase the deductible to $78 in 1987.

CONCLUSION

In conclusion, we believe our 1986 Medicare proposals are absolutely necessary to bring the growth in health care costs more into line with the growth of other areas of the economy. We cannot support any measures that might contribute to a growth in the Federal deficit. Our Medicare proposals build on the success of this Administration in reversing the escalation in health care costs which had jeopardized the retirement security of elderly Americans. We must continue our efforts to assure that the financial stability of Medicare is not threatened and beneficiaries will receive necessary health care in the future.

I will be pleased to answer any questions you may have.

Chairman STARK. Thank you very much, Dr. Davis. In your across-the-board review on Medicare, you have touched all the areas.

Why didn't you propose freezing the capital payments?

Ms. DAVIS. I'm sorry, sir, I did not hear.

Chairman **Stark**. You froze everything else in Medicare in a sort of across-the-board freeze. Why did you not propose freezing Medicare capital payments?

Ms. **Davis**. The capital payments. We anticipate sending the report due to Congress soon on the whole area of how to pay for capital, and therefore——

Chairman **Stark**. On what?

Ms. **Davis**. How to pay for the capital expenditures—there is a report that will be sent forward to Congress that will deal with that particular subject.

Chairman **Stark**. Now, there were four other reports that I think we asked for—treatment of sole community hospitals, teaching hospitals and payments for uncompensated care and coordinating part A and part B payments.

I assume we will get those four reports before we get the one on capital payments.

Ms. **Davis**. Well, I believe that the four reports that you have mentioned are in final circulation inside my agency at this point in time.

I have seen the one on sole community providers—and I believe there will be a departmental clearance within the next few weeks' time.

Several of the other ones should come in rather quickly, too.

The issue of uncompensated care is one that I have not yet had the opportunity to review myself. That's a very complex issue. I would hope that we will move the report expeditiously, and I give you my word we will. However, we do need to take the time to analyze it and make sure that the policies that we would recommend are appropriate.

Chairman **Stark**. When do you expect the capital payment study?

Ms. **Davis**. The capital payment study I believe is in departmental review; it's not one that our agency is responsible for. But I can certainly submit that information to you for the record.

Chairman **Stark**. The report indicated that that could be frozen along with everything else.

What will be the revenue effect of that, if we had that as an option, do you know?

Ms. **Davis**. No, Mr. Chairman, I would have to submit that for the record.

Chairman **Stark**. In other words, that might have an effect on work flows, that might give us *x* billion dollars in other areas.

I guess I'm curious because we haven't received a cost report. It is my understanding that OMB is looking at the four of them. But we haven't received the cost report, as I understand it, since 1981 or 1982, whatever. And we are interested in knowing what's going to happen to the hospitals under the freeze proposals.

Is there any chance that you could get the 1985 report, the old format, or the new format, if it's available, so that we could look very closely at what these proposed freezes would do in particular segments of the hospital?

Ms. **Davis**. Well, let me just back up and explain one or two things in relation to the cost report. Hospitals do have a certain length of time after the close of the fiscal year in order to complete the report and send it in.

We did have some delay in terms of structuring what we needed to look at in relation to the cost report forms for prospective payment. That has now been cleared by OMB and that form is out now. So we will be collecting the data from the first year as expeditiously as we can on that particular format.

The 1983 reports, I believe, are in process now, and we should be getting that data in house this summer.

Chairman STARK. When was the first year we started the DRG?

Ms. DAVIS. 1983.

Chairman STARK. We almost need that to know what your freeze is going to do to the new format of payments, is that fair?

Mr. SCOTT. Mr. Chairman.

Chairman STARK. Yes.

Mr. SCOTT. The cost report, as you are well aware, is a very extensive document, and each time there is a change in the Medicare statute, we have to revise it. The change in TEFRA caused a major alteration to the cost report. Moving from TEFRA to the first year of PPS—again, significant kinds of changes.

It was the change from TEFRA to PPS that took us longer than we had wanted it to, and that first-year PPS cost report, as Dr. Davis has said, has completed its final review and is ready for distribution.

Chairman STARK. With the instructions? It's the instructions that are missing.

Mr. SCOTT. I don't think that we would have the nerve to send out the report without the instructions.

Chairman STARK. I think that's going to be very important for us to be able to assess, and I expect for you to know, what the freezes will do to hospitals. I don't know what they did in 1985 or really have any idea what they will—except from their testimony, which will come later—what will happen in 1986 under the proposed freeze, or the particular increases. I really think we have a very weak data base to make decisions. Even with—for instance you—does that make sense to you, fulfilling our contracts with the profession?

Ms. DAVIS. But, Mr. Chairman, we still have worked out a methodology with respect to the physician fee freeze where we recognize that as simply a delay of a year in the length of time before the system is updated. We have looked at this, and have determined that, assuming a freeze for one more year, we would still be able to recognize——

Chairman STARK. Something like make the increase tax free?

Ms. DAVIS. What we would do is say if you participated for 2 years, then you would have the ability to have your actual charges recognized throughout that period of time. I think we face some very tough problems. We are all cognizant of the fact that the budget in general is in a deficit state, and, of course, the $18 million——

Chairman STARK. We really have the duty to uphold our end of the bargain; it does seem to me this is an area where we should keep our word. I can understand extending it, but if I can understand compound interest, so can a physician—particularly if he is paying on a loan, he would be very aware.

Mr. Gradison.

Mr. **Gradison**. Thank you, Mr. Chairman. Dr. Davis, on page 4 of your testimony you refer to "* * * recent reports of increased profit margins in hospitals * * *" you have a freeze on physician payments, and yet you are anticipating that physician costs are going to go up 12 percent next year.

Why is that?

Ms. **Davis**. We were anticipating that without the freeze these payments would go up 12 percent. With the freeze I believe it is much less than that.

Chairman **Stark**. I was under the impression that they were still going up 12 percent with the freeze. I misread.

Ms. **Davis**. I state in my testimony that without the freeze, there would be an increase of 12 percent; there would be an increase even with the freeze because of the increase in quality.

Chairman **Stark**. While we are on physician freezes, it is my understanding that in an effort to encourage physicians to accept mandatory assignment, you said if you sign up for mandatory assignment, we promise you an increase in your fees in October; and you further said if you don't sign it, we promise you that you are not going to get an increase.

And we are really trying to twist them to sign up for mandatory assignment.

Now those physicians who are promised the increase—and a small percentage of them did sign up, 24-percent signed the agreement to accept assignment—how does that square with our credibility with the medical care providers?

Could you submit for the record these reports? I would be interested in particular in seeing how they might break down in terms of regions, in terms of whether they are public or private hospitals, and so forth.

Ms. **Davis**. I don't think that we have that documentation as much as what we read in the popular press. We do know that one of the hospital associations has been keeping track of some of that. Our best data is that in the past Medicare was paying roughly about 72 percent of the hospital charges—that's now up for all hospitals; 76 percent, indeed, for hospitals under prospective payment. It's more like a range of, I think, 84 or 86 percent of all charges.

Mr. **Gradison**. But here you are not referring to that; you are referring to profit margins—I mean, the fact that the hospitals aren't losing as much money on Medicare as they did before doesn't necessarily explain increased profit margins. All I am asking for is what you used as a basis for it.

Your initial statement indicated a savings of $1.8 billion in the next fiscal year for the hospital freeze portion. If we were instead to follow the recommendations of ProPAC, which I think was for a marketbasket of minus 1 percent, or something like that, what savings would that provide?

Ms. **Davis**. I believe, Mr. Gradison, I will have to submit that for the record. You are asking me to submit to you, if we took the ProPAC recommendation, what that would actually save versus what we have. Since the ProPAC report just came out I think on

Friday, I would have to have my actuary take a look at that, and we will be happy to submit it.

Mr. **Gradison**. I would really appreciate it if you would do that as soon as you possibly can. Very frankly, I would like to go beyond the statements of the chairman about this, because I think this whole freeze thing involves a breach of faith with the hospitals as well as the physicians.

And I am very concerned that there is going to be enormous pressure to slow down the transition to the DRG system, if we go to the 1-year payment freeze.

By the way, if we adopt your recommendations for the 1-year freeze on hospitals, what is your position on a 1-year slowdown in the transition?

Ms. **Davis**. I believe that our position has been very clear. We think that we should continue to move toward the total transition to a national rate system.

Mr. **Gradison**. Dr. Davis, a moment ago, in answer to a question that Mr. Stark raised, I understood that you, in talking about physician fees, indicated that there might be an increase in volume that would accompany the freeze. I assume you meant an increase in volume to a higher level than if you didn't freeze.

Is that what you were saying?

Ms. **Davis**. We always recognize that you have two factors when you are dealing with outlays: One is the price and the other one is the volume of services. And if you put a control on the price only, then you are apt to see an increase in the volume. Our actuaries, when they figure estimates, do make certain allocations that assume this increase. And that is what I was referring to.

So even with a freeze we would have probably about a 3-percent increase in our total outlays.

Mr. **Gradison**. I understood that the 3-percent increase would in fact cut in half the savings of the freeze because of increased volume.

Is that approximately correct?

Ms. **Davis**. Yes.

Mr. **Gradison**. Well, what does that mean in terms of the beneficiaries?

They are going to have some more copayments to make, they are going to have some more out-of-pocket expenses, because we are stimulating more volume by a freeze?

Is that a correct summary of the situation?

Ms. **Davis**. No; I think that the correct summary would be that if we don't have the freeze in actuality you could assume that there would be higher payments that the beneficiary is going to have to face. Although there might be some minor increase in services under the freeze, we anticipate that without the freeze there will be an increase in the total outlays for beneficiaries because the copayments would increase with volume of services. Without a freeze, all prices for service would be going up at a great rate; therefore the beneficiaries would be paying larger dollar amounts of copayments.

Mr. **Gradison**. So, we hit them either way.

Ms. **Davis**. Yes; I think we hit them stronger without the freeze.

Ms. **Kelly**. There is also the issue of the premium, the beneficiary's share in whatever decrease in the part B fund there is with the premium rates that we set.

Mr. **Gradison**. With regard to medical education costs, I understand you have a study underway on this matter. What's the status and when might we get it?

Ms. **Davis**. I believe that study is due in in its preliminary form this month.

Mr. **Gradison**. When will it reach us?

Ms. **Davis**. Well, we certainly will use an expedited process of reviewing; however, a preliminary report does not mean final, it means the first time we receive it for review. It is a joint report that is sponsored by the Assistant Secretary for Planning and Evaluation, the Assistant Secretary for Health, and HCFA—so it needs to have the concurrence of all of those units, and then be sent to the Secretary's office for review.

I would think it would be several months before we would have that ready to send to Congress.

Mr. **Gradison**. So, you are making a recommendation with regard to medical education costs and the role of Medicare without having had a chance to examine the study which you commissioned on the subject; is that a correct statement?

Ms. **Davis**. That is correct, but I think that there are some other factors that we do know that made it easier for us to arrive at that particular conclusion. We know that the costs in direct medical education have been going up rather dramatically. Particularly since these have been passthrough costs, there has not been any incentive to want to make reductions in that particular area.

While the law itself is perfectly clear that we need to cover the salaries of interns and residents, when the program first started, we expanded that through regulations and covered indirect services, such as books and instruction and things of that nature, as well as extending the provisions to other types of health care practitioners.

We are aware of the fact that there is now a surplus in almost all areas, and it seems very clear that we ought to begin to take some steps to bring that down.

The freeze on direct medical education payments is a result of simply looking at these facts.

I think the study itself will help us to frame the long-term response.

Mr. **Gradison**. Can you assure us that we will get that eventually?

Ms. **Davis**. I beg your pardon? Could I assure you what?

Mr. **Gradison**. Can you assure us that we will receive a copy of that study eventually?

Ms. **Davis**. Oh, yes; eventually—there is no reason why you should not.

Mr. **Gradison**. Let me indicate why I state it that way. I am still waiting to see the study which was due in 1983 on hospices, and I tell you very frankly that that's not the only study which illustrates this point. I am getting tired of our mandating studies and not getting the results. Sometimes it's just a question of not getting them on time; in some cases not at all.

And while the assumption has been in writing requests for studies that HCFA is the only place you could look for them, that really is not true. We can look to the Congressional Budget Office and we can look to the General Accounting Office.

As a matter of fact, at least in one instance, because of some concerns about the studies and quality of studies you had underway, we instructed the General Accounting Office to look over your shoulder.

And I only say this because we get criticized when we make decisions without the whole information. And yet I have reached the belief that in some instances information is in the hands of your department which is not shared with us. I would cite the issue of disproportionate share and intensity of care.

I am not absolutely sure of what I read in all the health newsletters; they often make mistakes and so do I. If it's correct that you have got a study arriving on some kind of paper, just because it can't be xeroxed, it raises some questions about what the purposes of our asking for studies are.

And I wanted to use this as an opportunity to comment on it, because I think it's a matter of general concern.

With regard to the question of premature discharges, the General Accounting Office did a brief study based on about one-half dozen communities—they made a report, and there was a hearing held in the other body.

Do you have any systematic means of monitoring this? Are the PRO's your principal arm, and, if so, when do you think we will be able to get a comprehensive feel on what is happening with regard to the impact of the DRG's on the condition of patients of this type?

Ms. **Davis**. Yes, we monitor that, and we get a monthly report from the contractors and the peer review organizations.

Peer review organizations are asked to look at any readmission within 7 days. We assume that if there were any prematurely discharge of patients with significant problems, you would see a substantial rise in the number of patients who would be coming back in for further treatment, or you might find an increase in mortality rate or something of this nature. We have been watching all of those factors. We've had no change at all in mortality rate.

The number of readmissions that are occurring within that corridor of time is running about 1.3 percent, which we think is within a normal range. Obviously, any time you have people that are ill, there are a certain number that will have something else happen to them, sometimes not even related to their first illness.

Nevertheless, we do have a very aggressive program in which we have asked the medical review entities, who see something that they think merits further look with respect to premature discharges, then they are to notify our regional office.

We have an occasional situation where we find an individual hospital that may exhibit that kind of behavior. We are working on a new regulation that would speak to allowing us to take more specific sanctions in those cases, but there are very few of them.

Mr. **Gradison**. One final question—and I want to thank the Chair for his indulgence.

Dr. Davis, some 10 States and increasing numbers of business firms are adopting requirements for second opinions for surgery. There has been some testimony in the other body that up to one-third of Medicare outlays for surgery could be saved by the application of such a program in the Medicare Program.

What is your position on that? We might be able to do it in this next bill. You might consider adding such a requirement as an alternative to some of the changes that you have recommended.

Ms. **Davis**. I think those would be false savings, Mr. Gradison. That study was done prior to the implementation of the prospective payment system and prior to our peer review organization activities.

Peer review organizations are mandated to carry out a preadmission review of 5 out of the top 20 diagnoses, so many of that list of seven or eight procedures mandated for second opinions would be the same ones that are already mandated as subject to preadmissions reviewing. Each State is allowed to target its own 5 out of that list of 20.

But we believe—in fact, we know—there are some significant changes in the number of inpatient procedures. Let me give you one example. Cataract surgery, which in the first full year of prospective payment was running tied for the second place in terms of the dollar outlays—in other words, it was second in terms of all our inpatient DRG's—has now dropped to sixth place as a result of the peer review and the monitoring system that is now in effect.

So I think that we will see more of that activity, because the peer review organizations really came on board and began to do their activities primarily last October.

Mr. **Gradison**. Is that study that you mentioned involving cataracts based on hospital inpatients or does it include outpatients?

Ms. **Davis**. That is based on inpatient hospital procedures.

Mr. **Gradison**. Well, I'm not sure it means a whole lot, because there is a very high proportion of ophthalmological surgery being done on an outpatient basis these days—and that has changed just in the last 2 or 3 years.

Ms. **Davis**. That's true.

Mr. **Gradison**. Well, I still haven't got an answer to the question. You did say that second-opinions by physicians save some money.

Ms. **Davis**. The report did indicate it would save money. My comment was I do not think that there would be the savings that report alleged, because that report was done prior to prospective payment.

Second, it was done on a young-age population in a Medicaid setting. So, I think, those two variables need to be considered.

Our belief is that with the aggressive program that we now have, under peer review, that the purpose of a second opinion program is met, and there isn't a necessity for a mandated second opinion program.

Mr. **Gradison**. Basically, it started out by mandating certain procedures that are particularly prevalent and gaining some actual experience, rather than guessing as to the effect it might have on the real world.

Do you have any objection to that?

Ms. **Davis**. I again believe that our peer review organizations will be doing a very aggressive job. I think it's too early to write them off as not being successful. It seems to me that if we have time to see exactly what they are doing and how aggressively they have been able to contain this particular problem, I think you will find that they solve that particular problem without creating another mandated review.

Mr. **Gradison**. I don't want to belabor this, but I don't understand how they are really going to take up many of these cases. It's one thing after the fact, after the surgery is performed, to take a look; but it's something else beforehand, after one opinion, for somebody else to take a fresh look at that patient before the surgery is done to determine whether it seems to be necessary.

I understand your point, but I just sense a reluctance to try it—and I can see how it might be attempted on a limited category to see how it works. It's worked pretty well with business firms, they say; and some States are requiring it of their public programs.

Ms. **Davis**. Well, I think, too, that the sentinel effect that we have seen from the peer review—remember that the Peer Review Organizations do have a preadmission review—not all of their cases are, although in some specific States they are under a total preadmission review; for example, Kentucky chose to do preadmission review on all their emergency cases.

So I think where you see some of these activities going on, you find a sentinel effect from peer review, where hospitals know that PRO's are targeting on preadmission review on at least five diagnoses, and then make a random selection for review.

We are now reviewing roughly one-third of all hospital cases under peer review, and that is a very, very large amount of activity.

Mr. **Gradison**. Thank you, Dr. Davis. Thank you, Mr. Chairman.

Chairman **Stark**. Mr. Coyne.

Mr. **Coyne**. Thank you, Mr. Chairman. I would just like to followup on the line of questioning that Mr. Gradison has taken, and that is inasmuch as the proposals that have the cost of the teaching hospital, what you would expect would be the outcome of the proposals relative to the nature and the size of the programs that the funding now calls for. What would you expect would happen to the programs and the size of the programs in the teaching hospitals?

Ms. **Davis**. Well, as soon as there is a freeze, there would be no incentive to continue to increase the number of individuals that are being educated. We already know from the records that there is an abundant supply of almost all health professionals now. Since direct medical education payment will be frozen, we think that would begin to provide incentives for the overall reduction in the number of individuals who are being trained, and perhaps bring more efficiencies into the system. The indirect expenditures that are still paid is an area where one can shift more costs, particularly when prospective payments come along.

Mr. **Coyne**. Am I to understand that you feel that a reduction in the number of those being educated wouldn't be a disadvantage?

Ms. **Davis**. Well, I certainly don't think it would be a problem at this point in time. We know there is projected to be a surplus of physicians in the early 1990's.

Mr. **Coyne**. Thank you very much.

Chairman **Stark**. Mr. Daub.

Mr. **Daub**. Thank you, Mr. Chairman. I will try to keep my focus between the chairman's admonition to look at descriptively how we maintain today's level of services in 1986, and the baseline, which is the prospective payment rates proposed to be maintained in 1986 at the 1985 levels.

Let me make a comment to you, then ask you two questions. My questions strictly relate to the revised wage index report which was filed on March 28, this past Friday.

The inequities in prospective payments, with respect to that wage index, as you well know, have gotten a lot of attention from my colleagues in the past 4 or 5 months. Congress did receive this report from the Secretary of Health and Human Services last Friday. The Deficit Reduction Act, which passed in July 1984, mandated that the Secretary of HHS issue a revised area wage index within 30 days of the adoption of that act.

I first want to say I recognize the complexity in reevaluating the hospital data and recognize that 30 days was certainly a difficult deadline to meet. But, we have been waiting, waiting, waiting, and so are the hospitals.

I think quite honestly that we have waited entirely too long for this report, and as a result of the delay, whatever reasons it occurred, I don't think that we can delay implementation. I want to ask you a couple questions and press for immediate initiation of rulemaking and a swift implementation of the revised indices.

Many hospitals are struggling under the current faulty area wage indices. This morning I reviewed the report that was filed last Friday, March 28. I found that the estimate of additional revenue that would have accrued to the hospitals in rural Nebraska and the urban Omaha MSA for the period of October 1, 1983, to September 30, 1985, under the revised index exceeds $3 million for each area. That is for a 2-year period. For Omaha, specifically, this amount ranges from over $3 million to over $4 million, depending on whether the gross adjusted index is used.

My point is that these hospitals have been unjustly penalized by a faulty index, and Congress, as well as your Department, recognize that problem. We mandated a report and after, in my opinion, too many delays, we finally have received the report.

First, I understand that you have two indexes. Can you explain the difference between the two and give me some idea of which one you think will be implemented?

Ms. **Davis**. I think what you are referring to is that we try to contrast between the gross figures, which use the labor data, inclusive of physician salaries. That is what we referred to earlier today as the gross index.

The other wage index is without the physician salaries component in it. And we refer to that as the adjusted gross hospital salary.

We were trying to lay out two different scenarios showing the impacts on both of these, and, although there are variations, I think that the trends are in the same direction; where a hospital received an advantage, it seemed to receive an advantage of additional moneys under either of these, adjusted gross or the gross.

Likewise—and I would point out that while your hospitals, Mr. Daub, did come out favorably, there are some rural areas that don't come out so well. For example, in rural hospitals in Indiana, their payment will be reduced we estimate by approximately $1.8 million.

So there are some aberrations inside of the system itself, fluctuations.

Mr. **DAUB**. I appreciate that there will be winners and losers in the readjustment.

I want to get the differences between the two indices on the record. The first index is derived from total gross hospital wages, which includes salaries and wages for contracted labor, interns and residents, personnel employed in nonhospital cost centers, and hospital-based physicians, am I right?

Ms. **DAVIS**. Yes.

Ms. **KELLY**. Yes, sir.

Mr. **DAUB**. The second index, based on the HCFA survey data, uses adjusted gross hospital salaries in its construction. That is, salaries and wages of contracted labor interns and residents, personnel employed in nonhospital cost centers, and hospital-based physicians are not included in the computation?

Ms. **DAVIS**. Yes, the hospital-based physicians are the piece that is not included in adjusted gross.

Mr. **DAUB**. I want to make this point to you as we proceed to evaluate which of these indices will be used that your report says hospitals indicated they have had difficulty in determining the wages and salaries and hours worked for the excluded-worker categories used to develop the adjusted gross wage index. I think that that adjusted gross index is likely not to be as accurate as the gross measure of direct wages.

Would you care to comment on that?

Ms. **DAVIS**. We believe that the second one is more complicated to calculate.

Mr. **DAUB**. In other words, the first index, at least to me, looks a little bit better.

Ms. **DAVIS**. The second one is more complicated to calculate.

Mr. **DAUB**. Thank you, Doctor. I want to proceed to my last question.

Will you proceed to—and, if not now, when—to rulemaking and to the issuance of a revised index?

Ms. **DAVIS**. Mr. Daub, the Secretary said, when she testified recently before one of the committees, that she wanted to formulate the final recommendations after Congress had had the opportunity to review the document, and she wanted to consult with Congress once the document was here.

So at this stage we now are awaiting more review; I think we will be in contact with Congress to try to formulate some opportunities for interaction.

Mr. **DAUB**. Was there an intention to try to get this done by October 1, the beginning of the next fiscal year? Are these hospitals going to get retroactive lump-sum payments, or what is going to happen?

Ms. DAVIS. Well, again, I think the whole issue of retroactivity is a very complicated one because of the large swings in payments—not just for rural hospitals.

I think when we initially went into this, we had an assumption that this would automatically mean additional dollars for pretty much all rural hospitals; at least I think many people thought that, and indeed we certainly thought so, too.

But it turns out that there are some fairly enormous swings not only in reducing payments to urban hospitals, but also to some of the various rural hospitals because of the large impact of retroactivity caused by the 2-year timeframe.

I think that it was important to get the report out and to analyze it in its entirety, and then to make some decisions as to what to do.

Mr. DAUB. I realize that recoupment and redistribution could have consequences. I also know that we are now operating with 1981 BLS data which doesn't take into account the part-time employment basis of many of the smaller rural hospitals.

Now, everybody has agreed, the Congress and your Department, that this is unfair. So notwithstanding whether there are swings in the new revised indices, it seems to me that the objectivity applied should still remain the same. What's fair is fair. We must proceed down this road and assure these hospitals that very promptly they are going to be able to have a recoupment. I am speaking of those that have been discriminated against by the choice of a wage index that did not fairly reflect their labor costs.

So I trust that we are not going to go back and argue over what is fair, is that correct?

Ms. DAVIS. I would repeat that the Secretary has indicated that she wants to hear from Congress on this issue, and I will certainly relay my conversations here today.

Mr. DAUB. Do you plan to issue revised rulemaking in 1 month or 2 months, or what is your plan at this point?

Ms. DAVIS. I cannot answer specifically on that.

Mr. DAUB. When will you be able to answer it, in a week or two?

Ms. DAVIS. I would think within a week or two we would be in a better position to assess it.

Mr. DAUB. I would like you to inform the chairman of this committee and our ranking member, and all of us, if you would, please, within the next 2 weeks as to when precisely you plan to issue the rulemaking procedures required to maintain these hospitals that are so affected by the potential revised rules.

Would you do that for me?

Ms. DAVIS. Certainly.

Mr. DAUB. I appreciate that. Thank you, Mr. Chairman.

Chairman. STARK. Mr. Rangel.

Mr. RANGEL. Thank you, Mr. Chairman.

Dr. Davis, is it your testimony that the recently enacted reforms on cost containment and cost sharing are not going to have any adverse impact on the quality of care to Medicare recipients?

Ms. DAVIS. Mr. Rangel, I am not certain I heard all of what you said.

Mr. **Rangel**. You have done a great job in showing how much money you save. I just asked you whether or not it implies that there has been no decrease in the quality of care as a result of these reforms in cost sharing, et cetera.

Ms. **Davis**. We have been monitoring the quality of care, and we will continue to do so aggressively. Obviously, our first line of defense has been to look at the activities that the peer review organizations are doing.

But I think that there are several things that we find as a result of what happens in the hospital. Now we can begin to see perhaps even some improvements in the quality of care—and let me recite two or three issues. And, admittedly, they may have been economically driven, but the outcome, I think, is good.

No. 1, in order to reduce the length of stay—and we know the length of stay has been dropping for all patients, not just in prospective-payment hospitals, but across the board, but more so with prospective payment—there has to be a better tracking of what is going on in the system.

Normally, hospitals now, are assigning either a DRG coordinator, a primary nurse, or someone who is responsible for making certain that the patterns of care are followed through correctly and that they don't slip and forget to premedicate somebody and have to delay them another day in the hospital, which used to happen.

Second, we know that they are beginning earlier with patient education and family education in order to prepare them to go home, and beginning early for planning for discharge.

Now, all of those things, actually, I think are improving the quality of care.

Mr. **Rangel**. How do we know, Doctor—we have a GAO report, prepared by the Senate, that is different from what you testified earlier.

Ms. **Davis**. Well, the GAO report is largely anecdotal interviews with individuals.

Mr. **Rangel**. I am not arguing with their report or your findings, but how do we in the Congress know that these patients are not being prematurely discharged? How would we know whether they are going to a skilled nursing facility, or whether they are going home and receiving adequate care, unless there is something that you are sharing with us?

Ms. **Davis**. We have a report on the first year of prospective payment, which is pretty much the kind of data that I have been sharing with you now, and which we will be sending forward very shortly.

But we have a very active monitoring program; we track this data coming in each month. We can tell the volume of patients that are being referred to skilled nursing facilities or home health care.

That has gone up only about 1 percent, and yet I think many people would expect it would go up a lot more than that.

We are on track in terms of the mortality rates, the readmissions within 7 days, the transfers—all of these must be reviewed by our peer review organizations, which are medical review organization.

Mr. **Rangel**. Is there any tracking as to whether or not the poor or lower-income patients have longer periods of stays in the hospital or more serious illnesses?

Ms. **Davis**. The initial studies that we did a couple of years ago, working with the National Public Hospital Association and an outside firm, looked at this and could not determine if there was any difference in terms of the acuity levels of patients in a public hospital.

What they did note was that those hospitals bear a larger burden in terms of the uncompensated care, the charity care.

Mr. **Rangel**. Have you got a list of those hospitals, even the private hospitals, that have more than their share of Medicaid and uncompensated cases? I believe we are trying to see how we should treat these hospitals, and we are waiting for guidelines from your office so that we could properly legislate.

Do you have any idea——

Ms. **Davis**. I think you are referring to the request that this committee made that we send up a list of hospitals that had a disproportionate share of the low income.

Mr. **Rangel**. Yes.

Ms. **Davis**. We have been trying very hard to locate a source of data with which we would feel comfortable, because currently the hospitals do not report on that. What we had to do was to take a 4-year-old report from the Office for Civil Rights.

Mr. **Rangel**. I thought I just suggested it, while you were talking about the Medicaid and the Medicare reimbursements and the uncompensated cases.

Ms. **Davis**. Well, may I clarify where we are on that?

Mr. **Rangel**. Sure.

Ms. **Davis**. We looked at the whole issue of using Medicaid as a proxy for the disproportionate share of low income. Now, that is fraught with some problems, because different States have different entitlement levels for Medicaid. Therefore, if you use Medicaid as a proxy, you are going to have variations across the States, since some hospitals will have a larger volume simply because the cutoffs for Medicaid in that particular State are at a richer level than they are in another State.

Nevertheless, we ran the data that we had, and the data came out very strangely. We had large aberrations in it, so much so that we had to question that particular data source; because you had hospitals like San Francisco General or Parkland in Texas, which showed up as not having any Medicaid patients.

On the other hand, we had a hospital in Arizona show up as having Medicaid patients and Arizona didn't even have a Medicaid Program at that point in time.

So there were very strange things in that data. So we sat down to try to identify another source by which we could define that list of hospitals.

We are now trying to work with another data base, which I hope within the next month's time we will have determined if it is a valid source. Likewise we have another study now going on to try to use the census data on poverty levels and to bring in that data base and perhaps merge it with this other in order to determine a true list.

Meanwhile, we have a separate study that looks at the whole issue of uncompensated care.

So there are many factors involved, and they are very complex.

I notice that even the ProPAC group could not come to any resolution or identify how you determine that list of disproportionate-share hospitals—not for lack of trying; it's simply that there is not a data base.

Mr. **Rangel**. Well, Mr. Chairman, I would like to submit some questions to Dr. Davis, but I find it hard to believe that we cannot determine by census tracks or by programs that are designed to serve the poor—if the American Hospital Association has such list of hospitals—there is no question that every Member of Congress would be able to recommend that you look at some of the hospitals in their districts for you to determine whether they are receiving more than their share of poor people who cannot afford to pay for health care.

I have known for some 30 years that hospitals reject certain patients, that certain hospitals cannot afford to do that, and these patients are delivered by private and public ambulances to these hospitals.

We know where they are, and Dr. Davis must not wait for a study in order to find a way to compensate these hospitals for providing for the public good. I don't know what kind of basis you need.

But you also are saying, Dr. Davis, that you have no evidence to substantiate that poorer people, or those living in poorer communities, have any need for longer hospital stays or have more serious illnesses?

Ms. **Davis**. What I am saying is that the initial data that we looked at indicated to us that the case mix index adjusts for the level of acuity within a given hospital. However, it looked like the major problem in public hospitals was not that the patients were sicker or stayed longer, but that there was a very much larger volume of patients who were charity care, totally uncompensated care, and that that seemed to be the problem.

Mr. **Rangel**. That is not my question. I am not arguing with what you are saying—and I don't know what your basis is, so therefore I cannot dispute your finding based on what you were looking at.

What I am asking you, Dr. Davis, based on all of your experience and involvement in the field of the care of the ill, can you reach a judgment that poor people admitted to hospitals normally have more serious illnesses and require longer stays?

Ms. **Davis**. No, I can't make that judgment, because I think you have to have empirical evidence in front of you. Any judgment I would make would be purely anecdotal and based upon whatever hospital I happened to have been working in at that point in time.

Mr. **Rangel**. Would you be able to make that same judgment if you were talking about poor communities as relating to those that have been designated by your bureau as being medically underserved?

Would you say that using Federal criteria in designating an area that is considered medically underserved and the people who live in medically underserved areas, have a tendency to be sicker than those who live in other areas?

Ms. DAVIS. I think we would have to go back and look at the data in terms of those specific areas and bring in some other material relative to morbidity, or relative to the illness level in those hospitals.

Mr. RANGEL. But what do you mean when you say an area is medically underserved? That is your language. You say that areas have been designed by HHS as being medically underserved.

Ms. DAVIS. I think that, Mr. Rangel——

Mr. RANGEL. I know what I am seeing, and there are a lot of sick people and poor folks, and our hospitals are overcrowded, and we can't discharge them because there is no place for them to go; there are no nursing homes for them to go to; we cannot send them home—they don't have social workers; they don't have adequate housing.

You are saying you don't have any basis for reaching the determination that poor folks don't get sicker and don't stay longer even in medically underserved communities?

Ms. DAVIS. Well, the designation of a medically underserved community is made by the Public Health Service.

Mr. RANGEL. Is that part of HHS?

Ms. DAVIS. It is part of HHS, but I only deal with the Health Care Financing Administration. We do not make those designations.

Mr. RANGEL. Well, suppose for instance, you saw what I am saying is medically underserved—and you have hospitals that are in these communities, don't you?

Ms. DAVIS. Yes.

Mr. RANGEL. So one part of the Federal Government says it is medically underserved, and you are responsible for reimbursing those that do serve.

Can't you answer whether or not you believe that the burden is not just in terms of uncompensated cases—you don't need a study to say that poor folks sometimes can't pay their bill—but you can't determine by any type of evidence as to the degree of illnesses that people have in these areas that are admitted to hospitals?

Ms. DAVIS. What we would have to do would be to look at those areas that the Public Health Service has designated as underserved—and they have been designated that primarily under the assumption that there is a lack of physicians in that community. It is my understanding that that is their major criterion.

Mr. RANGEL. Do they include physicians that may or may not be in hospitals?

Ms. DAVIS. Since I am not familiar with their criteria, I would submit that for the record.

It is my understanding that——

Mr. RANGEL. Do you have any budgetary problems in getting these studies together?

Ms. DAVIS. I'm sorry—do I what?

Mr. RANGEL. Do you have any budgetary problems in getting the studies that are mandated by the Congress together?

Ms. DAVIS. No, I think our major concern is in terms of the large volume of studies that we have. As you know, when we went into prospective payment, Congress did decide to give us a larger number of studies, quite a number of which are due now. We have an additional number, about twelve more, that are due in December.

And I think one of the things we have had to do is to identify, through our private contractors who are in research policy development areas, the way in which they can help us with various parts of those studies. And then once those research data are completed, we have to analyze and develop the information into a final report.

Most of the reports that are due are in that final report stage.

Mr. **Rangel**. And you have been able to do this notwithstanding the one-third cut in your budget? You can handle it?

Ms. **Davis**. Well, the one-third cut in the budget that you are referring to is in the budget for next year.

The administration has proposed that we have $22 million for our research activities next year, which is indeed a one-third cut.

What we will do is target very specifically and issue RFP's for approximately four different study areas that we have a need for including looking at the whole area of how to develop a physician DRG payment system, and the integration of a skilled nursing facility payment into the DRG system. Those are two of the reports.

We have an evaluation component for which we will be requesting a proposal, and then we will be doing a study which we refer to as an intermediary at risk.

Those will be the only studies that we will be doing new next year, and we will cancel our normal solicitation for new grants next year.

But I think we have enough funds in house and we have made enough progress on the studies that Congress has already asked us for to assure we will complete them.

If you ask us for new studies, we would have to either wait until we have some money the following year, or ask for additional funds in order to do the new studies. But that would be for new studies mandated by Congress this year's hearings.

Mr. **Rangel**. So you are telling the Congress that the executive branch has already decided that if we want new studies, you can't afford to do them?

Ms. **Davis**. No; I am simply saying that the studies you have already given us, are on track, and we are going forward.

Mr. **Rangel**. What about the new studies that we may ask for?

Ms. **Davis**. New studies would have to be looked at in terms of priority, and I would either have to make a decision not to fund one, or wait for another year, or take something we are already funding and reduce its funding in order to fund that.

Mr. **Rangel**. Thank you, Mr. Chairman.

Chairman **Stark**. Mr Matsui, welcome to the committee. You may inquire of this witness.

Mr. **Matsui**. Thank you very much, Mr. Chairman. I would like to thank you and the other members of the committee for allowing me to participate today. I appreciate it very much.

Dr. Davis, I share the other members' concern, and especially Mr. Rangel's concern, about the study of the disproportionate provider language. Hopefully, that report will be forthwith as we proceed toward a budgetary decision.

Second, of course, I am very interested in the study of the effects of the DRG's in hospitals in specific areas. That study was undertaken last year, and it seems to me before we really get into the budget issues on Medicare, we should have these documents.

In addition, Mr. Chairman, I have a series of ten questions which I have prepared in the last few days, and I believe most of them fit the guidelines of the Chair's admonition to all of us here.

I would like to submit them for the record for Dr. Davis to respond to.

Mr. RANGEL [presiding]. Without objection.

[The following was subsequently received:]

DEPARTMENT OF HEALTH AND HUMAN SERVICES,
HEALTH CARE FINANCING ADMINISTRATION,
Washington, DC, May 13, 1985.

Hon. FORTNEY H. (PETE) STARK,
Chairman, Committee on Ways and Means, Subcommittee on Health, House of Representatives, Washington, DC.

DEAR MR. CHAIRMAN: In reply to your recent request, I have enclosed my responses to questions submitted by Messrs. Matsui and Rangel for inclusion in the written record of the April 1 hearing on the Medicare budget for FY 1986.

I appreciate the opportunity to present the Administration's views on these issues.

Sincerely yours,

CAROLYNE K. DAVIS, Ph.D.

Enclosures.

RESPONSES OF ADMINISTRATOR DAVIS TO QUESTIONS POSED BY CONGRESSMAN MATSUI

1. Question. What are your intentions with respect to the application of revised area wage adjustments for hospitals under the prospective payment system (PPS)? Will the adjustments be effective October 1, 1985, or will there be retroactive application of the new schedule to all hospitals from the date they become subject to PPS?

Answer. On March 29, 1985, the Secretary submitted to the Congress the wage index report required by section 2316(a) of Public Law 98-369. That section requires the Department of Health and Human Services (DHHS) to develop a revised wage index which addresses the inability of the present wage index to control for regional variation in the employment of part-time hospital workers.

The law also requires that any changes made in the hospital wage index under section 2316(a) shall be retroactive to October 1, 1983. Therefore, adoption of a new wage index which resolves the part-time employment problem under present law would mean that hospitals that are currently being underpaid would receive retroactive compensation. By the same token, we would be required to recoup amounts where hospitals have been overpaid. I point out that because retroactive implementation of any new wage index is required by law, we have little administrative discretion in the matter.

The wage index report contains two alternative indexes developed from a specially designed survey of hospitals subject to the PPS conducted by the Health Care Financing Administration. Both indexes address the part-time employment limitation because each is based on the average hourly wage of specific categories of hospital workers within each urban/rural area for which a wage index is constructed.

The report contains no recommendation as to whether either of the survey-based indexes should be adopted. We believe that the Congress and other interested parties should be afforded the opportunity to comment on the report before we further consider the implementation of a new wage index.

2. Question. Have you completed your analysis of the costs of hospitals serving a disproportionate share of Medicare or low-income patients? What are your conclusions? Have you developed criteria or a definition of "disproportionate provider" and can you estimate the number of hospitals that would qualify? Do you have a proposal for adjusting PPS payments to such hospitals? When do you intend to make it operational?

Answer. Before the Federal Government adjusts payments to any hospital or group of hospitals, it must determine whether any above average costs are caused by special circumstances (such as sicker patients) in the hospital(s) or simply by operational inefficiencies.

We performed a preliminary analysis based on a 2-week survey of hospitals conducted by the Office of Civil Rights in January-February 1981. The survey data are highly questionable. For example, hospitals known to have high Medicaid patient loads showed up on the survey as having none.

Because these data are lacking in precision and completeness, HCFA is investigating alternative sources of data for measuring a hospital's share of low-income patients. We are now looking at data from the American Hospital Association's Annual Survey and from the Medicare Cost Report.

In the long run, the problems of disproportionate share hospitals may be resolved pending the outcome of our studies on severity of illness and inclusion of this variable in the prospective payment system. In the meantime, HCFA has done significant amounts of work to define disproportionate share hospitals. We have taken this Congressional mandate seriously and will report the results to Congress as soon as they are available.

3. Question. What do you believe is the feasibility of a modification to PPS payments to take better account of patient severity differences within the same DRG? Do you intend to implement such a revision and how quickly?

Answer. The original PPS legislation (P.L. 98-21) requires the Secretary to study the application of severity of illness, intensity of care, and other factors to the Medicare prospective payment rates. Recommendations to Congress on these issues are to be included as part of the 1985 Annual Report on the Medicare prospective payment system. The research for this report is still underway, but preliminary findings will be available by late 1985.

Our overall strategy for approaching this problem involves examining how to identify and correct variations in patient treatment requirements occurring between patient groups, hospitals, or types of hospitals. To do this, we have developed a phased approach:

Short range (1985-1986)—define and make plans to acquire a data base for adequate comparisons of competing classification strategies. This agenda might also include activities which would yield immediate results such as new ways to compute weights for DRGs, ways to sharpen the DRG classification system, and ways to use information about previous patient treatment.

Intermediate range (1987-1988)—study whether there are real, unmeasured variations in patient treatment requirements between hospitals and how to update both the DRG classification system and pricing to reflect changes in practice and technology.

Long range (1990)—develop and test case-mix systems which represent a full generation of advance over the present DRGs and which consider variables such as the degree of previous diagnostic knowledge about the patient, the purpose of the admission, psychosocial characteristics of the patient, and whatever issues concerning severity of illness have been proven important in the intermediate range research.

4. Question. Have you developed any new approaches to resolution of the problems created by arbitrary boundaries that result in significantly different payment amounts for similar services by hospitals in close proximity to one another? Can we make the distinctions between urban and rural areas less abrupt?

Answer. The Medicare law requires that payments to hospitals be established on the basis of geographic region and urban/rural location. The law further defines an urban area as an area within the boundaries of a Standard Metropolitan Statistical Area (now known as a Metropolitan Statistical Area), as designated by the Executive Office of Management and Budget, or within such similar area as the Secretary has recognized in accordance with the regulations establishing limits on hospital inpatient operating costs under the Tax Equity and Fiscal Responsibility Act of 1982. Counties outside the designated metropolitan areas are considered rural.

Although we are required by law to maintain an urban-rural distinction in administering the PPS, we recognize that certain hospitals, particularly facilities located in rural counties adjacent to urban areas, maintain that they are disadvantaged by this policy because they incur costs comparable to those of urban facilities. The implication is that an alternative means for aggregating counties to develop payment rates more reflective of economically integrated areas needs to be investigated.

We have acknowledged the need for further research in this area and are examining a number of alternatives. In this connection it should be noted that the PPS legislation requires the Department to study and report to Congress, as part of the 1985 Annual Report on the Medicare prospective payment systems, the feasibility and impact of eliminating or phasing-out separate urban and rural payment rates.

This report will enable us to determine the extent to which changes in the urban/rural classification system are necessary and appropriate.

5. Question. Have you examined the quantitative effects of continuing the transition to national rates in the absence of further refinements to PPS and assuming a freeze on prices and reductions in payments for indirect costs of graduate medical education programs? What kind of institutions will be adversely impacted? Do you have any contingency plan for dealing with financially distressed hospitals?

Answer. As you know, we are proposing to maintain the prospective payment rates at the fiscal year 1985 level for one year. This reflects a programmatic, not a budgetary decision. Hospitals are responding to PPS by becoming more efficient. Lengths-of-stay have dropped significantly, thereby reducing costs for routine services. We also believe that hospitals have shared in the productivity experienced by the nation as a whole. In addition, new economic forecasts show the hospital marketbasket for 1985 to be less than was projected when the 1985 rates were established. For these reasons, we believe the current rates will be adequate for an additional year.

The positive results of PPS convince us that the 3-year phase-in from a combination of individual hospital-specific and regional rates to a fully national prospective rate should continue as scheduled in current law. We will, of course, continue our research and studies to develop refinements in the rate-setting system.

With regard to medical education, we have no evidence that paying hospitals twice the amount calculated for the indirect cost of medical education is necessary. To the contrary, industry publications have reported that in the first year under the prospective payment system, most hospitals have increased their profit margins, especially major teaching hospitals.

We believe that the prospective payment system will provide adequate payment rates for all hospitals in 1986. However, we are actively investigating any adjustments that may be necessary in hospitals serving a disproportionate number of low income and medicare beneficiaries.

6. Question. Do you believe, based on estimates available to you, that the range of gains and losses experienced by hospitals under PPS is acceptable? Are we rewarding efficient behavior and punishing those who have been wasteful?

Answer. While we do not currently have information on individual hospital costs under the PPS, most reports incidate that hospitals are doing well under the system.

The question of whether we are rewarding efficient behavior on the individual hospital level is very difficult one to answer. If it were possible to validly identify individual hospitals that are efficient and those that are inefficient, one could simply institute a reward and punishment system for individual hospitals, based on those measures.

There are strong signs that prospective payment is having the intended effect on efficiency. The average length of stay for Medicare patients in short-stay hospitals under the PPS during fiscal 1984 was 7.7 days—down substantially from the figure for the previous year. It has been reported that ancillary services per patient day seem to be falling, as well. At the same time, there are no signs of any decrease in quality of care.

The effectiveness of PPS incentives for hospital efficiency will continue to be monitored as the system develops over time. At the same time, studies are being developed to examine the extent to which these incentives may affect the quality of hospital care and the access of Medicare beneficiaries to that care, since these considerations are also of paramount importance in evaluating the performance of the new system.

7. Question. Have you examined the effect of PPS incentives on hospital admitting practices?

Answer. When the PPS was created, there was concern that the new system, in paying on a per case rather than on the previous cost basis, would provide an incentive for hospitals to increase the volume of admissions. As a result of this concern, the volume of admissions became a primary focus of HCFA's PPS monitoring effort.

In the years prior to the implementation of the PPS, the volume of Medicare short-stay hospital admissions had exhibited a steady upward trend, rising from about 9.4 million in calendar year 1978 to about 11.7 million in calendar year 1983, or at an average annual rate of about 4.2 percent. During this period, admissions per thousand enrollees grew from 353 in calendar year 1978 to 395 in fiscal year 1983, an increase of almost 12 percent.

Under the PPS, however, we have observed a decrease in Medicare admissions, rather than the anticipated increase. During fiscal year 1984, the first year of the PPS, there were an estimated 11.5 million Medicare short-stay hospital admissions—a decrease of almost 2 percent from the previous year. Admissions per thousand enrollees has also decreased from 395 to 381, or about 3.5 percent. Recent data show that the decrease of Medicare admission rates has occurred in every geographic region and in almost every State during fiscal year 1984.

Whether the observed decrease in Medicare admissions has been caused directly by the PPS, or whether and to what extent other charges occurring in the health care sector may be responsible, is difficult to ascertain. We do know that admission rates for non-Medicare patients have also been decreasing. We will continue to monitor and analyze this phenomenon as more information becomes available.

8. Question. Given the effects resulting from a prospectively set price, how far should we go in reducing the amount of the price? With the savings being achieved now, are further payment reductions necessary and when will we know that we've gone too far?

Answer. The propective payment system (PPS) was designed to use a system of average costs and prices to encourage the cost-effective provision of hospital services. To date, we have anecdotal evidence that most hospitals are doing well under PPS and we believe that they will continue to prosper as the system moves to national rates. Hospitals' continued well-being, however, will be a function of their ability to adjust their production activities to be more efficient.

We believe that the rates we have established are adequate to maintain the quality of health care provided to Medicare patients. We have not proposed reducing the prospective payment rates but want to maintain them at the current level for an additional year, for reasons noted previously.

Peer Review Organizations will be closely monitoring hospital care provided under the PPS to assure that care continues to meet quality standards. The PROs' efforts will be contemplated by our continuing research on quality issues which will indicate changes in case-mix and severity of illness.

9. Question. What analysis have you done on the effects of a price freeze on hospitals that are presently experiencing losses under PPS?

Answer. To date, we have only anecdotal information about the financial status of hospitals, but the preponderance of it seems to indicate that hospitals are generally doing well under PPS. Therefore, have believe that our proposal will not seriously affect hospitals' financial status.

10. Question. The Administration recently pointed to evidence that hospitals in the aggregate generated over $4 billion in revenues over expenses. Do you know what proportion of hospitals account for these surpluses? What kind of hospitals have positive bottom lines and which do not? Do you know anything about the distribution of these hospitals—by type, by size, by geographic location, or by type of ownership?

Answer. As stated above, HCFA does not currently have information on individual hospital costs under the PPS. What we do know is that prospective payment and other cost containment initiatives instituted by both public and private payers for hospital services have changed the way that hospitals function, so that speculation based on past hospital behavior might be misleading.

However, given the gradual implementation of the PPS (the average short-stay hospital was covered by Medicare's prospective payment for only a little over half of fiscal year 1984) and the heavy first year emphasis placed on the hospital's own historical costs (75 percent of the prospective payment rate for fiscal year 1984 was based on hospital-specific costs), it seems unlikely that any sizable group of hospital would be experiencing financial hardship solely because of the PPS at this point.

As we begin to receive cost data from hospitals under the new system, we will be able to more carefully examine the issues raised by your question. These issues, in fact, are a major focus of several studies being planned or conducted by HCFA as required by the PPS legislation.

RESPONSES OF ADMINISTRATOR DAVIS TO QUESTIONS POSED BY CONGRESSMAN RANGEL

1. Question. Home health services are advertised as cost efficient because they allow a beneficiary to stay out of expensive hospitals. What impact will the imposition of a copayment requirement have on home health services? Do you think the use of such services will decline? Will there be a greater emphasis on in-hospital services as a result?

Answer. We have found that home health services are, in fact, less expensive than hospital care only when they can be substituted on a one-to-one basis. Unless home health services can be accurately targeted to patients who would otherwise be hospitalized, overall costs are greater because of an increased use of home health care.

We believe that a copayment for home health care would encourage the appropriate utilization of these services. In the past, the General Accounting Office has found that about a quarter of claims made for home health care were for medically unnecessary or noncovered services. Another study we recently completed resulted in similar findings.

We do not believe a modest copayment would inhibit the use of home health care since the average beneficiary would face an annual cost of only $24 in 1986. In addition, we do not believe payments of $4.80 per visit after the first 20 visits would foster the increased use of inpatient hospital services. Enactment of a copayment would conform home health to hospital and nursing home benefits. Currently, home health care is the only major service provided without cost-sharing by the beneficiary.

2. Question. There have been newspaper reports about a deterioration in hospital care because nurses are being laid off in response to the PPS system. Does HHS believe that this is a problem? If so, will the DRG freeze make things worse? How can we counter it?

Answer. I believe the growth in hospital expenditures can be restrained without compromising the quality of care. To date there is no evidence linking behavioral changes that have taken place in the hospital industry under PPS to any problems with quality of care.

There has been particular concern expressed that the decline in Medicare average length of stay may compromise the quality of patient care. However, we have no data showing an increase in the number of deaths or complications resulting from shorter patient stays.

If nurses are being laid off, I believe it is in response to a number of factors. The hospital industry has experienced a significant decline in occupancy levels and hospital admissions for all patients, which may result in a reduction in staffing levels.

While the goals of PPS are to provide incentives for hospitals to improve efficiency and thereby reduce hospital expenditures, these goals are not incompatible with the maintenance of quality of care.

Maintaining quality of care is a major HCFA goal. We are closely monitoring the quality of care through the Peer Review Organizations (PROs) under contract with HCFA. The PROs have responsibility for evaluating whether the quality of services meets professionally recognized standards of health care. Where problems arise PROs intervene to require corrective action.

3. Question. Since the enactment of prospective payment Medicare beneficiaries are being discharged from the hospital nearly 2 days earlier. Where are these people going? Has the use of skilled nursing facilities or home health increased?

Answer. For discharges recorded under the Prospective Payment System in 1984 and in fiscal year 1985 year-to-date, hospitals reported the following percentage distributions of discharge destinations.

DISTRIBUTIONS OF DISCHARGE DESTINATIONS

	Fiscal year—	
	'1984	1985
Home, Self-Care	80.9	80.6
Short-Term Hospital	1.6	1.4
Skilled Nursing Facility	5.3	5.5
Intermediate Care Facility	2.6	2.5
Other Facilities	1.0	1.0
Home Health Services	3.1	3.4
Left Against Medical Advice	0.2	5.3
Died	5.3	5.3
Total	100.0	100.0

The use of skilled nursing facilities and home health agencies appears to have increased slightly recently.

Admission rates to Medicare participating skilled nursing facilites accelerated in fiscal year 1984 rising from 19.0 admissions per 1,000 Medicare enrollees in fiscal year 1983 to 19.9 in fiscal year 1984 compared to an increase from 18.5 admissions per 1,000 enrollees in fiscal year 1982 to 19.0 fiscal year 1983.

Preliminary estimates indicate that home health visits increased about 11 percent in fiscal year 1984 to about 39 million visits over fiscal year 1983 compared to an 18 percent increase in fiscal year 1983 over fiscal year 1982. The earlier large increase rate can be attributed in part to the expansion of home health benefits enacted in the Omnibus Reconciliation Act of 1980 (P.L. 96-499).

4. Question. Are Medicare beneficiaries being discharged from the hospital sicker? Are there adequate nursing home beds available in all areas? Are nursing homes currently prepared to handle these sicker patients?

Answer. We have no evidence that there is a system-wide problem with premature discharges under PPS, and have moved aggressively to ensure that this does not occur.

HCFA requires peer review organizations to report all cases of hospital readmissions that, while medically necessary, appear to reflect premature discharge from a previous hospital stay. When cases are reported, PRO's perform intensified review and work with specific physicians to ensure appropriate admissions and discharges.

We have had only scattered reports of Medicare patients experiencing problems with access to skilled nursing facility (SNF) care. A sharp increase in the number of "swing-bed" hospitals which provide both hospital and SNF levels of care has improved access in rural areas.

5. Question. As I understand it, hospitals can now determine whether a Medicare patient will be admitted to the hospital for certain things (such as cataract surgery) and if the hospital decides the patient should not be admitted, Medicare will not cover it. Further, having made that decision, the hospital can then tell the elderly patient that he may pay for the hospital admission out of his own pocket? Aren't these HHS regulations asking the fox to guard the chicken coop?

Answer. The policy which allows hospitals to notify Medicare beneficiaries that their hospitalizations will not be covered under Medicare is not a "new" policy but has been in effect for many years. This policy has assumed increased importance with implementation of the Peer Review Organization (PRO) program. PROs assure that the care provided is medically necessary and appropriate. The PROs perform a large majority of their review on a retrospective basis and issue denials, where appropriate. Hospitals perform review and issue notices of noncoverage, where appropriate, to keep the beneficiary informed of Medicare coverage policy and to protect themselves from being held financially liable for providing care which is not medically necessary or appropriate. Where a hospital issues such a notice, the beneficiary may opt to elect admission and pay for the noncovered stay out of his own pocket. The PROs monitor the notices of noncoverage issued by hospitals and will work with hospitals to correct instances where notices are issued inappropriately.

6. Question. You are proposing to freeze payments to physicians for an additional year. This proposal will control the price of service—but not the quantity of services provided. Have physicians been increasing the number of services that they have been providing to increase their Medicare reimbursement.

Answer. The Deficit Reduction Act of 1984 mandated that the Department provide a report to Congress on the changes in the per capita volume and mix of physician's services that may have occurred as a result of the fee freeze. In order to prepare this report we are examining trends in existing data as well as requesting additional data from a sample of our carriers. We expect to complete the report in time to meet the July 1 due date.

Preliminary evidence, however, is that physicians are not trying to "game" the income constraints of the fee freeze in this fashion. Additionally, you should be aware that HCFA is doing intensified medical review to protect beneficiaries from this potential problem.

7. Question. Your physician proposal freezes payments to both participating and non-participating physicians—it seems to me that one way of encouraging physicians to participate would be to increase their fees, while freezing the non-participating physicians. Do you have a problem with this approach?

Answer. The Senate/White House compromise would freeze fees for non-participating physicians for 12 months beginning October 1, 1985. The compromise gives participating physicians an increase in their payments for fiscal year 1986. In the context of the Administration's support of the compromise with the Senate leadership, we would not be opposed to the Senate proposals for physicians if the entire deficit reduction package is accepted by the Congress.

8. Question. I understand that there has been a significant increase in the physician assignment rate under Medicare. Do you attribute this increase to the participating physician arrangements?

Answer. We believe that the participating physician program has had a positive impact on improving the financial protection afforded by part B of Medicare. During the first quarter of the participating physician program, the percent of dollars for all charged-based services accepted on assignment was 63.9 percent. That was an increase of 14 percent over the same quarter in the previous year and 8 percent over the previous quarter. Previous annual increases had been in the range of 2-4 percent. During the January-March quarter, payments made under assignment continued to increase dramatically reaching 66.9 percent.

The increase in payments made under assignment is attributable both to the mandatory assignment provision for independent lab services and the participating physician program. Given the relatively small size of individual lab billings, the assignment change in this area could not alone have accounted for the dramatic increase in the percent of covered charges accepted on assignment.

9. Question. What is the status of the American Medical Association's law suit against Secretary Heckler?

Answer. On April 18, 1985, the U.S. District Court dismissed the suit against Secretary Heckler. Some of the counts were dismissed "with prejudice."

10. Questions. What steps do you think we could take to increase the number of participating physicians?

Answer. Within the framework of present law, we do not believe very much more can be done to increase the number of participating physicians. This issue will be examined more closely in our report to Congress, due July 1, 1985, on including physician payments in the prospective payment rates.

11. Questions. I understand that about 30 percent of all physicians are now participating physicians. The percentage of physicians that are participating seem to vary widely by state. For example—in Pennsylvania over 50 percent of physicians are participating compared with only just over 10 percent in Oklahoma. What are the reasons for this wide variation?

Answer. An individual physician's decision to participate depends on many factors, including: physician supply and the competitiveness of the local market; extent of the physician's practice devoted to treating Medicare patients and the interest in increasing the number of Medicare patients; historical assignment practices; and relative reimbursement rates.

Assignment rates historically have varied from state to state; experience under the participating physician program is consistent with this previous experience.

12. Questions. I am concerned about the cuts in the administrative budget of the Medicare program. Medicare contracts with intermediaries and carriers (such as Aetna, Blue Cross) to process Medicare claims. This year there is an anticipated workload increase of over 10 percent, yet the budget for claims processing has barely been increased. Isn't it pennywise/pound foolish to scrimp in this area of the budget?

Answer. The Medicare administrative budget for claims processing takes into account workload growth, inflation and other demands. However, these factors are offset by contractor productivity savings and by expected economic efficiencies which Medicare contractors, particularly high cost contracts, are trageted to achieve without reducing the quality or processing output of their operations. Funding for items which return money to the trust fund is being increased. These activities include audit, medical review and identification of other coverage to which Medicare is the secondary payer. Additionally, we have increased funding for beneficiary communications.

13. Questions. Under the Administration proposal, the HCFA research budget has been cut about one third—from $33 million to $22 million. Considering the large number of overdue reports, not to mention the significant number of reports that will be due soon, how are you going to manage with this significant reduction? Please be specific.

Answer. We have carefully targeted our resources to assure continued funding of research addressing the priorities that have been expressed by both Congress and the Administration. The proposed budget also permits us to target additional resources on those new initiatives of highest priority to the Administration. Within our agenda-setting process, we will continue to be responsive to the concerns of Congress.

We will soon share with the Committee our suggestion concerning congressionally mandated reports which we believe are now obsolete and deadlines which are not workable.

14. Questions. The Administration budget proposes a significant reduction in HHS staffing. How will this affect HCFA?

Answer. HCFA will focus priorities to ensure effective and efficient administration of its programs. Staffing resources will be reduced through normal attrition rather than by actions that would adversely affect HCFA personnel (such as involuntary separations). Employees associated with the direct reimbursement function (transferred to Medicare contractors) have already been reassigned to similar positions in other components where activities were the most critical, thereby obviating the need to fill many vacated positions. In addition, we will reallocate resources from lower priority functions to more critical areas; for example, administrative support functions and related staffing which are carried out at one or more organizational levels throughout the Agency will be reduced. And finally, there will be a continuing increase in activities that are "contracted out" such as data entry, typing and mail operations.

15. Questions. Each year the Administration proposes zero funding for the ESRD Networks. Each year the Congress funds them. Instead of requesting repeal or zero funding each year, why don't you give the Networks more guidance and make them into an effective part of the Medical Information System for the renal program?

Answer. We have provided guidance to the Networks, and they have become an effective part of the Medical Information System for the renal program. However, by eliminating the ESRD Network Coordinating Councils and transferring their functions to other programs HCFA administers, costs will be saved and administrative efficiencies gained with no adverse impact on the ESRD program.

Mr. MATSUI. Now, I just have one series of questions dealing with the whole issue of the freeze pertaining to prospective payments.

I have been hearing a lot not from the for-profit hospitals but from nonprofit hospitals, their problems in many areas—and it isn't so much the treatment of the medically indigent itself, but it is the fact that over the years these nonprofit hospitals have been using some of that money for the work of taking care of these uncompensated patients. And, of course, in areas that Mr. Rangel represents, in areas of Los Angeles County, Chicago, where there are a lot of indigent patients, when these people go to the nonprofits, of course in the past they have taken them, because they were subsidized for these patients by the fact that they had Medicaid and also Medicare. Many of them are today saying they are not able, as a result of the prospective payment system to take care of these indigent patients.

In view of the fact that there have been these problems and in view of the fact that we are moving to national rates, if the freeze on Medicare this year passes, what effect will this have on these hospitals? It seems to me the effects would be devastating.

Ms. DAVIS. I think that one of the things that you seem to be attributing the problems to is the prospective payment itself. One of the things we have to remember is that because of the sentinel effect of the Peer Review Organizations, we have seen a significant drop in overall admissions. And many institutions I believe are facing some restructuring—and they think about the number of beds and exactly what their admissions are within that particular geographic area—not because of the prospective payment rates as much because their overall admissions have dropped, dropped rather significantly. If I could just mention as part of this whole issue that we do not believe we should slow down our transition to a national rate. I believe there is merit in moving forward.

I realize that you have sponsored an amendment in the past to slow it down, but I think this administration's position is that we would like the incentives in the system to continue. We believe that the incentives to change behavior are powerful and we should continue forward toward the national rate.

Mr. MATSUI. I think frankly it is going to have a very significant adverse effect on nonprofit hospitals, given that we have a continuation of the prospective system, adding the rate at the same time as the freeze.

In reference to your comment regarding the drop in admissions and also the drop in length of stay, I think you are absolutely right, there has been a dramatic drop in both of those areas.

I am hearing from some of the supervisors in California, county supervisors, that are saying they can't take the indigent patients at this time, and many of them are now being sent to the county hospitals who in turn can't take those people because of the financial strain on the local government.

And it seems to me that we can't deal with Medicare freezes because it's all interrelated. And I would like your comments on that, because it really is an issue that deals totally with freezes because once it drops out of the system, it's the noncompensated indigent patient that is not covered by private, by Medicaid or Medicare, and he or she then gets no treatment at all.

Ms. DAVIS. You are referring to your conversations with individuals in the State of California. Of course, I am aware that California Medicaid has its own rather new bidding system and also is paying prospectively.

Mr. MATSUI. Yes; and I do appreciate your sensitivity to that.

Ms. DAVIS. And I believe that that system covers all providers, not just Medicare and Medicaid. And I think other third parties equally want to assure cost-effective delivery of care, so we find that the same type of intense scrutiny, looking for efficiencies in the system, is applicable to all payers.

Mr. MATSUI. Somehow we have to deal with this issue, and I certainly hope we deal with it before we deal with the budget, because I find it almost impossible to deal with the issue of the freeze not knowing what the effect would be.

Thank you.

Chairman STARK. Are there any other questions?

Thank you very much. We look forward to your response to the written questions of the staff.

Ms. DAVIS. Thank you.

Chairman STARK. The committee will be in recess until the continuation of this hearing.

[Whereupon, at 3:35 p.m., the subcommittee adjourned, to reconvene at 10 a.m., Monday, April 15, 1985.]

1986 MEDICARE BUDGET ISSUES

MONDAY, APRIL 15, 1985

House of Representatives,
Committee on Ways and Means,
Subcommittee on Health,
Washington, DC.

The subcommittee met, pursuant to call at 1:05 p.m., in room 1100, Longworth House Office Building, Hon. Fortney H. (Pete) Stark (chairman of the subcommittee) presiding.

Chairman **Stark**. The Subcommittee on Health will come to order. The hearing will begin. We are holding our second hearing on the administration's 1986 budget recommendations for Medicare. A week or so ago, the Health Care Financing Administration explained what changes were suggested and why. Today and tomorrow we will be hearing from those who would feel the impact of those suggested changes.

At our last hearing many of us felt that we had a problem because of lack of data, the data relating to exactly what these changes would do in terms of the witness' own particular industry or group of professionals. The Chair, for one, while my members may not concur, is not particularly interested in hearing a lecture on quality.

One presumes that everyone in this room is interested in quality care. The question is would you use pieces of equipment, or would you pay your employees less, or your stockholders less dividends? The closer you can come to the microsense and tell us exactly what the proposed freeze or cuts would do to your individual operations, the more helpful it will be to this committee.

I would urge the witnesses who we will, by the way, hold very strictly to the 5-minute rule and allow more time as members are inclined to inquire. Any help the witnesses can give us will be appreciated.

We face a major deficit problem and there is a need for discipline in every legislative area as we struggle to impose greater controls on spending. We cannot make these changes or cuts without knowing the impacts of the changes on the providers of the care and ultimately on the patients.

That is our agenda today. Tell us, in the most impirical way, where you can, what exactly the impacts are of these cuts. As a secondary issue, if it is anything unique, what impact it will have on the patients. Our first panel consists of witnesses from two organizations that represent hundreds of thousands of older Americans, the American Association of Retired Persons, and the National Council of Senior Citizens.

Do we have panelists from those two organizations? Would you come to the witness stand, please? Vita Ostrander, president, American Association of Retired Persons, and Jacob Clayman, National Council of Senior Citizens—I know it is going to be difficult because none of your members are operating a hospital or sending bills directly to the Treasury, but to the extent that you can give us examples of how these budget cuts will affect individual cases, it will be appreciated.

You are going to see as each of you testify, those little lights flash on and the green light means you are fat city, and the yellow light means you have a minute to go. And the red light means you are supposed to stop. You have all very kindly submitted detailed statements which will appear in the record in their entirety, and any questions that the members may want to ask. If we go beyond our 5 minutes, we will ask that each witness be given time to respond to further questions in writing.

Vita Ostrander, if you would proceed, as you appear first, and introduce whomever it is that you have with you. I just ask you if you would withhold a moment. Mr. Gregg, do you have a statement?

Mr. **Gregg**. No, thank you, Mr. Chairman.

Chairman **Stark**. Mr. Pickle.

Mr. **Pickle**. No, Mr. Chairman.

Chairman **Stark**. You may proceed.

STATEMENT OF VITA R. OSTRANDER, PRESIDENT, AMERICAN ASSOCIATION OF RETIRED PERSONS, ACCOMPANIED BY CHRIS McENTEE

Ms. **Ostrander**. I have Chris McEntee with me, one of our staff. AARP believes that the administration's proposals to reduce Medicare spending by $19 billion and Medicaid spending by $7.2 billion over the next 3 years are neither fair nor balanced. While the proposals are a mix of provider and beneficiary cuts, most of the proposals would directly or indirectly shift costs now being borne by the Federal Government to program recipients.

Coupled with proposals to reduce Social Security benefits, the effect of the administration's proposals is to significantly reduce the incomes of older Americans while at the same time significantly increasing their out-of-pocket medical costs. Under these proposals, the average retired worker, who receives $461 per month in Social Security benefits, would lose $1,416 in Social Security benefits and pay $398 more out of pocket for Medicare premiums and deductibles over the next 5 years for a combined net loss of 1,814.

For the average retired couple, Mr. and Mrs. X, who receive $803 per month in Social Security benefits, the loss in Social Security would amount to $2,496 and Medicare out of pocket costs would increase by $796 for a combined net loss of $3,292 over the same time period. We believe that additional criteria rather than program savings alone must be considered in evaluating any proposal to cut the Medicare Program. We urge Congress to look beyond immediate budget savings in the Medicare and Medicaid Programs and adopt proposals which would reduce costs by creating a more efficient health care system for all Americans. Medicare pays for less than half the elderly persons' total health care bill. Beneficiaries now spend about 15 percent of their total income on medical care, ironically the same portion of their income that they spent prior to the Medicare. Even in the absence of any additional increases in costsharing or premium amounts, elderly out-of-pocket expenditures for medical care will likely reach 20 percent of income in 15 years.

If Medicare and Medicaid budget reductions are necessary to reduce the deficit, several options exist which are preferable alternatives to further cost shifting to program beneficiaries and private payors—insurers and individuals alike. These include raising the Federal tax on cigarettes and earmarking the generated revenue to the Hospital Insurance Trust Fund—and we are aware of your interest in this option—and establishing a mandatory second surgical opinion program for Medicare. Raising the cigarette tax to 32 cents per pack—the amount it would be if the tax had been indexed to inflation since its inception in 1951—would raise $4.5 billion in fiscal 1986, more than the total Medicare savings proposed by the administration.

Older Americans view the budget deficit as their chief economic concern. If these deficits continue, the economy could deterioriate and the elderly would be in further jeopardy. Proposals to reduce the deficit should address the real causes of the deficit—tax loopholes, military spending, and rising interest costs—rather than force older Americans to sacrifice still more. Thank you.

[The prepared statement follows:]

Statement of Vita R. Ostrander, President, American Association of Retired Persons

SUMMARY

1. AARP believes that the Administration's proposals to reduce Medicare spending by $19 billion and Medcaid spending by $7.2 billion over the next three years are neither fair nor balanced. While the proposals are a mix of provider and beneficiary cuts, most of the proposals either directly or indirectly shift costs now being borne by the federal government to program recipients.

2. As a result of legislative action over the past four years, Medicare and Medicaid spending has been reduced by $27 billion while defense spending has grown by $100 billion and corporations have benefited from large tax loopholes. In light of these imbalances, the Administration's Medicare and Medicaid proposals for FY '86 can only be viewed as unfair. Coupled with proposals to reduce Social Security benefits, the effect of the Administration's proposals is to reduce the real incomes of older Americans while, at the same time significantly increasing their out-of-pocket medical costs. Under these proposals, the average retired worker Mr. X, who receives $461 per month in Social Security benefits, would lose $1,416 in Social Security benefits and pay $398 more out-of-pocket for Medicare premiums and deductibles over the next 5 years, for a combined net loss of $1,814. For the average retired couple, Mr. and Mrs. X who receive $808 per month in Social Security benefits, the loss in Social Security would amount to $2,496 and Medicare out-of-pocket costs would increase by $796 for a combined net loss of $3,292 over the same time period.

3. Neither are the Administration's proposals effective. AARP believes that additional criteria, rather than program savings alone, must be considered in evaluating any proposal to cut the Medicare program. First, any proposal to change Medicare must correct the structural inefficiencies in the health care system rather than merely shift costs to beneficiaries and/or private payers of health care. Second, any proposal to change Medicare should improve the insurance status of the program rather than simply erode benefits for the Medicare population. Finally, any proposal to change Medicare must prevent the development of a two-tier system of care. We urge the Congress to look beyond immediately budget savings in the Medicare and

Medicaid programs and adopt proposals which would reduce costs by creating a more efficient health care system for all Americans.

4. Medicare's coverage of health care needs, while adequate in certain areas, leaves the beneficiary at considerable risk in others. Overall, Medicare pays for less than half of the elderly person's total health care bill. Beneficiaries now spend about 15 percent of their total income on medical care, ironically, the same portion of their income that they spent prior to the establishment of Medicare. Even in the absence of any additional increases in cost-sharing or premium amounts, elderly out-of-pocket expenditures for medical care will likely reach 20 percent of income in 15 years.

5. If Medicare and Medicaid budget reductions are necessary to reduce the deficit, several options exist which are preferable alternatives to further cost-shifting to program beneficiaries and private payers (insurers and individuals). These include raising the federal tax on cigarettes and earmarking the generated revenue to the Hospital Insurance Trust Fund and establishing a mandatory second surgical opinion program for Medicare. Raising the cigarette tax to 32¢ per pack (the amount it would be if the tax had been indexed to inflation since its inception in 1951) would raise $4.5 billion in FY '86, more than the total Medicare savings proposed by the Administration.

6. Older Americans view the budget deficit as their chief economic concern. If large deficits continue, the economy could deteriorate, which would place into jeopardy the programs on which the elderly rely and erode the elderly's purchasing power. In addition, older Americans do not want to see a huge debt passed to their children and grandchildren. But, just as AARP is concerned that the deficit be reduced, we are also concerned about how it is done. Proposals to reduce the deficit should address the real causes of the deficit—tax loopholes, military spending, and rising interest costs rather than force Older Americans to sacrifice still more.

STATEMENT

Thank you Mr. Chairman for this opportunity to present the views of the American Association of Retired Persons [AARP] on the Administration's proposals to reduce Medicare and Medicaid spending. My name is Vita Ostrander and I am the President of the Association. AARP is the Nation's largest membership organization of older persons, representing over 18.3 million older Americans.

The Administration proposes $4.2 billion in Medicare savings in fiscal year 1986 and $19 billion over 3 years. In addition, Medicaid is targeted for $1 billion in fiscal year 1986 and $7.2 billion over 3 years. AARP believes that these proposals are neither fair nor balanced. While the proposals are a mix of provider and beneficiary cuts, most of the proposals either directly or indirectly shift costs now being borne by the Federal Government to program recipients. Medicare and Medicaid have already been reduced by $27 billion as a result of legislative action over the past 4 years, while defense spending has been allowed to increase by $100 billion. Over the past 3 years, five of our largest corporations paid no taxes and received tax rebates of more than $1 billion even though they generated profits of $13.1 billion. In light of these imbalances, the Administration's proposals for further reductions can only be viewed as unfair. Coupled with proposals to reduce Social Security benefits, the effect of the Administration's proposals is to significantly reduce the income of older Americans while significantly increasing their out-of-pocket medical costs.

Under these proposals, the average retired worker Mr. X, who receives $461 per month in social security benefits, would lose $1,416 in social security benefits and pay $398 more out-of-pocket for Medicare premiums and deductibles, over the next 5 years, for a combined net loss of $1,814. For the average retired couple, Mr. and Mrs. X who receive $803/month in social security benefits, the social security loss would amount to $2,496 and Medicare out-of-pocket costs would increase by $796 for a combined net loss of $3,292 over the same time period.

Neither are the Administration's proposals effective. While the Administration appears to have made its proposals on the basis of program savings alone, AARP believes that additional criteria are more relevant for evaluating proposals to cut the Medicare program.

First, any proposal to change Medicare must correct the structural inefficiencies in the health care system rather than merely shift costs to beneficiaries and/or private payers of health care. While there appears to be some recent improvement in the rate of increase in health expenditures, medical care price growth still climbs at about twice the rate of general economy inflation. Unless the forces driving health care cost increases are addressed, Medicare will continue to face efforts to achieve budgetary savings alone, without any attempt to create a more efficient health care system.

Second, any proposal to change Medicare should improve the insurance status of the program rather than simply erode benefits for the Medicare population. Additional increases in beneficiaries out-of-pocket costs fail to address the fundamental forces driving health care costs inflation and have the most adverse effect on those enrollees least able to afford it, i.e. those who are very sick, the poor, and the very old.

Finally, any proposal to change Medicare must prevent the development of a two-tier system of care. Proposals which reduce only Medicare expenditures or change only Medicare benefits subject the elderly to the possibility of receiving less adequate care than that provided to the rest of the population. Unless the entire health care system is realigned, the elderly and their caregivers may find themselves at a significant disadvantage within our health care system.

Based upon these criteria, the Administration's Medicare and Medicaid proposals for fiscal year 1986 are extremely short-sighted and do not represent health care reform. We urge the Congress to look beyond immediate budget savings in the Medicare and Medicaid programs and adopt proposals which would reduce costs by creating a more efficient health care system for all Americans.

RISING OUT-OF-POCKET COSTS

The Administration's proposals to reduce spending in Medicare are based on the notion that the elderly are not health cost conscious—that they are somehow insulated by Medicare from the "true" cost of health care. Because of this insulation, so the theory goes, the elderly misuse or overuse the system and thereby increase Medicare costs. AARP rejects that theory.

Medicare's coverage of health care needs, while adequate in certain areas, leaves the beneficiary at considerable risk in others. Overall, Medicare pays for less than half of the elderly person's total health care bill. While Medicare covers about three-fourths of older persons' hospital bills, beneficiaries find themselves paying about 60 percent of their physician charges.

Beneficiary out-of-pocket liability for medical bills is considerable and growing:

In 1983, older Americans spent more than $8 billion to meet Medicare's cost-sharing requirements. This amount represents a 50 percent increase since 1981.

In 1983, charges associated with non-assigned claims totalled $2.5 billion, representing a 200 percent increase in just 6 years.

Beneficiaries experienced an 80 percent increase in their out-of-pocket liability for non-covered services and products between 1976 and 1981.

Annual premiums for Part B coverage, which will total $186 in 1985, have risen by 116 percent since 1977.

Beneficiaries now spend about 15 percent of their total income on medical care, ironically, the same portion of their income that they spent prior to the establishment of the Medicare program. Further, even in the absence of any additional increases in cost-sharing or premium amounts, elderly out-of-pocket expenditures for medical care will likely reach 20 percent of income in 15 years.

Increases in health care costs for elderly persons cannot be linked to excessive utilization of services. Indeed, for persons over 65, hospital admissions have increased only slightly over time, while average length of stay has dropped dramatically. Further, per capita physician visits by elderly persons have also declined since 1974.

Increases in health care costs pose special problems for the elderly poor/near poor. A recent Health Care Financing Administration (HCFA) study found that out-of-pocket expenses expressed as a percent of income were six time greater for poor/near poor older persons than for their middle-income counterparts. Moreover, fully one-fourth of the elderly poor/near poor are not protected by Medicaid. These persons are least likely to be spared the devastating effects of increases in health care cost in general, and in Medicare cost-sharing requirements in particular.

Moreover, as elderly beneficiaries age, their medical expenditures tend to rise. Not only do average per capita Medicare reimbursements increase as older Americans age, but so do their out-of-pocket expenditures for health care. Indeed, beneficiaries who are 80 years old and older experience out-of-pocket medical costs that are 1½ times those of persons 65 to 69 years of age. In addition, such increases occur as income declines; the average annual family income of persons 80 and older is only about 60 percent of the average annual family income of persons 65 to 69 years of age.

BUDGETARY ALTERNATIVES TO THE ADMINISTRATION'S PROPOSALS

AARP fully recognizes the dire need to place large and growing budget deficits on a steadily declining course. If Medicare and Medicaid budget reductions are necessary to reduce the deficit, several alternatives exist which are preferable to further cost-shifting to program beneficiaries.

We are pleased to note, Mr. Chairman, your bill which would extend the increase on the Federal cigarette tax and earmark the generated revenue to the Hospital Insurance Trust Fund. Since heavy users to tobacco products use a disproportionate share of health care resources, a user fee on cigarettes is an appropriate source of revenue for Medicare. Moreover, extending the current 16 cents per pack tax or raising the tax to 32 cents per pack generates substantial revenues for the Medicare Program. For example, raising the tax to 32 cents per pack (the amount the tax would be if it had been indexed to inflation since its inception in 1951) and earmarking the generated revenue to Medicare would generate $4.5 billion in fiscal year 1986, more than the total Medicare savings proposed by the Administration for that year.

A mandatory second opinion program for Medicare would offer significant benefits to Medicare beneficiaries, while at the same time, produce significant savings for the Medicare program. Though there have been many studies which elucidate the occurrence of inappropriate and unnecessary surgery, the work of Dr. John Wennberg on small area variations in physician practices clearly shows that unnecessary surgery occurs on a regular basis. Moreover, his analysis of the DRG categories shows that there is a huge amount of practice variation within each DRG. If those variations are not appropriately reduced, policy makers will miss the most important opportunity for achieving meaningful savings in the Medicare Program. AARP believes that an appropriate second surgical opinion program from Medicare could save hundreds of millions of dollars by reducing practice variations within specific DRGs, improving the ability of peer review organizations to monitor quality and utilization and providing an improved and more flexible benefit to Medicare beneficiaries.

THE ADMINISTRATION'S FISCAL YEAR 1986 BUDGET PROPOSALS TO CUT MEDICARE

The proposals which the Administration recommends in Medicare would impose new cost-sharing burdens on elderly Medicare beneficiaries and encourage providers to cost-shift to private payers (insurance and individuals). Among the proposals which impact directly on older persons are the following:

Delay in eligibility for Medicare

This proposal would defer eligibility to the first day of the month following the month of the 65th birthday. Currently, eligibility for Medicare begins on the first day of the month in which an idividual's 65th birthday occurs. This proposal would create a gap in health insurance coverage. While elective medical treatment may be delayed, the sudden onset of a life threatening illness—with its associated costs—would have a severe impact.

Increase in part B premium

This proposal, originally made by the Administration in its FY 84 Budget, would more than double the Part B premium by 1990 from $186 in 1985 to $408 in 1990. Increased out-of-pocket costs (over current law) to Part B enrollees would be $382.80 while for a couple it would be $765.60 over the period 1986 through 1990.

Physician fee freeze

This proposal would extend the current 15 month-freeze (July 1, 1984 to October 1, 1985) on "fee screens" for physician charges under Medicare Part B enacted in the Deficit Reduction Act of 1984. As a result, Medicare's allowed charges for physician reimbursement would be frozen for a total of over 2 years.

The current fee freeze allowed physicians to choose a "participating" (accept assignment in all cases) and "non-participating" (accept assignment on a case by case basis) option. As an incentive, "participating" physicians were allowed to pass along higher charges to be added to their record during the freeze period in order to receive more generous Medicare reimbursement when the freeze expired. Thirty percent of physicians have elected to become "participating" under the current freeze, a 10 percent percentage point (or 50 percent) increase over the previous 20 percent who agreed to accept assignment in all cases. Extending the freeze would break faith with these "participating" physicians by denying them their promised update in Medicare fee screens. The likely result is a drop in the participation rates and higher costs to beneficiaries. Moreover, the Administration's proposal does not include any of the necessary safeguards against higher beneficiary costs which Congress created as part of the original freeze, thus exposing older and disabled persons to cost shifting.

Increase part B deductible

The Administration would, beginning in 1987, increase the Part B Deductible annually by the Medicare economic index. This would increase the deductible from the current $75 of Medicare "reasonable charges" to $78 in 1986 and approximately $4-5 per year thereafter. It must be noted that $75 of "reasonable charges" under Medicare is often much more in actual out-of-pocket costs. Again this proposal merely increases beneficiaries' already high costs for physician's services, before services, by requiring high out-of-pocket costs before Medicare begins paying.

Copayments for home health visits

This proposal would establish copayments of 1% of the hospital deductible (or $4.50 a visit in 1986) for home health care beginning after the 20th visit. This proposal would fall only on those who experienced a lenghty illness, and penalizes those who use a less costly form of care.

Working aged

Under current law, workers aged 65-69 and spouses aged 65-69 of workers of any age, have the option of selecting employer-paid health insurance as their primary health insurance coverage, with Medicare as a second payer. This proposal would lift the age limit and extend this option to any worker's spouse age 70 and above as well.

Eliminating the age limit for the option of employer-paid health insurance coverage will raise the costs of employing older workers because the employer's insurance carrier will likely raise its premium rates due to the additional risk of coverage for older employers and spouses. A strong disincentive to the employment of older workers is the likely result. Moreover, the accompanying loss of income tax and payroll revenue to the federal government could more than offset any savings achieved in the Medicare program through implementation of this proposal. Only through increased employment can older workers be expected to maintain financial independence, and thus, less dependence on government income support programs.

Voluntary voucher

Under the proposal, Medicare beneficiaries would be given a fixed sum or credit with which to purchase their health insurance in the private insurance market. The purpose of the proposal is to restrain the rate of increase in health care costs by injecting a degree of competition in the choice of a health plan and by making consumers more sensitive to rising costs by asking them to assume a greater portion of such costs out-of-pocket.

The Association is concerned that setting a voucher amount could eventually invite Congress to limit the amount as a means for achieving budgetary reductions. Furthermore, AARP believes that further study is needed before any voucher proposal can be considered a realistic alternative to current Medicare benefits.

Perhaps the most difficult element of a Medicare voucher proposal is establishing a realistic voucher amount. AARP believes that the health states of the individual must be considered in determining a realistic benefit level or voucher amount in order for beneficiaries to be able to purchase adequate health care coveage. However, little data exists upon which to base such a modification. Further, vouchers assume that the consumer is sufficiently informed about the available alternatives in the private health insurance market. Unfortunately, past efforts to inform consumers about health care providers and options have been less than successful. Providing the necessary information in a timely, readable, and comprehensive fashion is far from assured in the Administration's proposal.

Hospital fee freeze

This proposal would freeze Medicare's DRG payments to hospitals at current levels for 1 year (fiscal year 1986) instead of allowing an increase for inflation. (Payments to skilled nursing facilities and home health agencies and PPS-exempt hospitals would also be frozen.)

At this point in the phase-in of the Medicare DRG program, it makes little sense to simply freeze DRG rates before we know what is really happening under the new system. A further tightening of Medicare payments could likely result in higher hospital charges for private payers as hospitals charge higher rates to these payers in order to regain lost Medicare revenues. In additon, a two-tier health system could result. If Medicare payments to hospitals become substantially less than private payments to hospitals, services to Medicare patients might decline.

THE ADMINISTRATION'S FISCAL YEAR 1986 BUDGET PROPOSAL TO CUT MEDICAID

The Administration proposes to freeze federal matching payments to states for 1 year and then limit future increases in federal matching payments to the GNP deflator. A recent variation of this proposal would eliminate the freeze, but would limit future increases in Federal matching payments to the medical services CPI.

AARP opposes any freeze or reimbursement cap on Federal matching payments. The states have already drastically cut Medicaid eligibility and services to meet the steep cuts in Federal matching funds for Medicaid enacted under the Omnibus Reconciliation Act of 1981. There are few opportunities to achieve additional savings in Medicaid without seriously jeopardizing the health of millions of persons, young and old.

Even if there were no deficit problem, Medicare's and Medicaid's costs and health care costs in general would require remedial medicine. Unfortunately, what the Administration proposes, treats only the symptoms and offers no cure to high health care costs. Moreover, it further burdens already overburdened Medicare beneficiaries and low income individuals, particularly the oldest and most vulnerable among us.

CONCLUSION

Older Americans are deeply concerned about the federal budget deficit. Our members view the deficit as their chief economic concern (a status previously reserved for inflation) for a number of reasons: first, if large deficits continue, the economy could deteriorate. If that happens, the programs on which the elderly rely are placed in jeopardy and the elderly's purchasing power is eroded; second, it is a family concern. Our members do not want to see a huge debt passed to their children and grandchildren.

For these reasons, AARP has consistently urged the President and Congress to reduce the deficit, and supported responsible efforts to do so: the Tax Equity and Fiscal Responsibility Act [TEFRA] in 1982 and the Deficit Reduction Act of 1984. AARP has supported these measures not because they exempted older persons from additional burdens, but because, on the whole, the packages were balanced. But, just as we are concerned that the deficit be reduced, we are also concerned about how it is done.

As a result of legislative action over the past 4 years, reductions in domestic programs have helped to reduce the deficit by over $500 billion while increases in defense spending and erosion of the tax base have added over $1½ trillion to the deficit. Proposals to reduce the deficit should address the real causes of the deficit rather than ask older Americans to accept reductions in their real incomes and higher out-of-pocket costs for medical care.

Chairman **Stark**. Perfect timing.

Ms. **Ostrander**. We practiced for it.

Chairman **Stark**. I will spot you the 30 seconds in the question period.

Mr. Clayman for the National Council of Senior Citizens—we have your statement, and if you would like to proceed in any manner you are comfortable, go right ahead.

STATEMENT OF JACOB CLAYMAN, PRESIDENT, NATIONAL COUNCIL OF SENIOR CITIZENS, ACCOMPANIED JANET MYDER, DEPUTY DIRECTOR, LEGISLATIVE OFFICE

Mr. **Clayman**. Thank you, Mr. Chairman. I have with me Janet Myder who is our deputy director of the legislative office that we have. There is a grave danger in all the political jockeying and legerdemain—I am confusing gerrymandering with ledgerdemain—going on between contending forces in Congress that the significance and importance of Social Security and Medicare to the elderly and our total society generally may very well be forgotten.

Together, they are the social engine that maintains a degree of economic security and health for millions upon millions of America's elderly. Without it, the overwhelming majority of senior citizens would live in abject poverty. Without these magnificant social tools, democracy and freedom cannot long endure in our country, and I say that with malice aforethought.

Consider for quick moment what the suggested changes in the Social Security COLA—forgive me if I stray for just a quick second—would inflict on older Americans. The CBO reported last week that the COLA cuts that the President and Republican Senate leaders advocate would increase poverty among the elderly by between 530,000 and 570,000 depending on inflation estimates.

Will that be considered progress in America if we achieve that result? Will that make the present administration and the President happy? Remember, Social Security recipients have already paid a harsh and high price for these past 4 years in terms of the many cuts they have had to endure. And so it is with Medicare.

Mind you, the administration over the past 4 years has squeezed spending reductions in Medicare Programs to the bitter tune of $27 billion. Not satisfied with that, the administration now wants to slash more and more of the Medicare Program—$41 billion we are told is the price tag over 5 years on this new avalanche meant to descend upon the oldsters.

Hit the elderly late and soon apparently is the administration's devout wish. We cannot solve any serious Medicare problems by cuts imposed on beneficiaries, by forcing upon them poorer health, by forcing upon them the risk of sickness. Our essential problem, if we are looking for solutions, is to control costs which have gone sky high, not because the elderly have insisted on more than necessary care. The elderly have not used hospitals and physicians unduly and beyond reason.

Health care is so costly—about twice the normal rate of CPI—because of the archaic nature of the health delivery system with which we live. We need something like the Kennedy-Gephardt proposal, and I quote directly from my testimony on page 10. "It—meaning the Kennedy-Gephardt proposal—assures savings without benefit cuts; it changes provider incentives, rewards efficiency, and builds, a nationwide system of health cost managment.

We urge the committee to seriously consider such a plan. If the bill has been adopted in the last session, we believe that today's hearing would not be looking for a way to cut Medicare. Don't let it be torn—I am talking now about Medicare—don't let it be torn piece by piece by those who adamantly opposed it at its very birth. It is a veritable lifeline for America's old people. Indeeed, it needs to be enhanced, not diminished.

You see it takes care of only 44 percent of the health care costs of the elderly. The old folks of the country, in our judgment, and in their judgment, cannot stand anymore harassment from this administration or anyplace else or anybody else.

[The prepared statement follows:]

STATEMENT OF JACOB CLAYMAN, PRESIDENT, NATIONAL COUNCIL OF SENIOR CITIZENS

Mr. Chairman, members of the Committee, I am Jacob Clayman, President of the National Council of Senior Citizens. The National Council represents over 4.5 million elderly persons in all 50 states. The majority of our members are Medicare beneficiaries who will be affected by the budget proposals which the President has presented to Congress. We appreciate the opportunity to comment on these proposals.

Our appearance before the Committee today marks the fifth consecutive year in which we have given our views on the Reagan Administration Medicare budget plans. During the last four years, this Committee has heard the concerns expressed by NCSC and other groups representing the elderly—that the budget reductions will be harmful to America's aged. The Committee members and their colleagues in the House of Representatives have managed to reject some of the most onerous burdens that the President would have placed on our members through his budget policy. Nevertheless, four years of this policy has resulted in Medicare spending reductions of $27 billion and significant cost shifting to the aged people whom the program was designed to protect.

Through budget reductions the aged are paying higher Part A and B deductibles, a higher Part B premium, and increased copayments for certain benefits than would have been the case under previous law. By enacting these reductions, Congress has primarily shifted costs rather than controlled spending growth through health care system reform. After all, costs are rising throughout the system, not in Medicare alone. Medicare outlay growth, consequently, continues to increase beneficiaries' cost-sharing levels and also pressures Congress to shift even greater financial burdens onto the aged.

This policy of failing to tackle the real causes of Medicare's cost growth, the incentives in our medical system which push up costs, is representative of the larger budget process as we have known it for the past 4 years. Instead of tackling the source of Federal deficit growth by reversing the policy of tax revenue loss amd military weapons spending increases, the President and the Congress have milked funding for domestic programs. This policy clearly is not working as the incessant growth of the Federal deficit demonstrates.

The President is now asking Congress to make dollar-for-dollar transfers from the domestic budget to the military budget. The fiscal year 1986 budget calls for a $30 billion defense increase and $30 billion in domestic spending cuts compared to FY 1985 levels.

How can Congress honor this request when four years of this unbalanced policy has removed over one-half million senior citizens and thousands of children from Medicaid rolls; deprived over 700,000 Americans of their access to community health center services; and left unsolved the growing problems of 33 million uninsured individuals?

We ask the Committee: for what purpose should senior citizens, children, working people, or the poor sacrifice again? The budget which the President has submitted to Congress projects that, if every one of his domestic funding cuts is adopted, the deficit by the end of fiscal year 1988 will be $160 billion, or double the deficit he "inherited" in fiscal year 1981.

We believe that not only is the Administration's unbalanced fiscal and budget policy harmful to older people, but the rationale used to justify cuts in programs for the elderly is harmful as well. There seems to be a serious misperception about the elderly's improved economic status. A variety of articles and publications, including the Report of the President's Council of Economic Advisers, have highlighted the economic gains made by the elderly over the past several years, while at the same time suggesting that perhaps the elderly should not have it so good. Without sufficient understanding of all the issues involved, the authors imply that the elderly are being selfish and are receiving more than their fair share of government spending. The unspoken recommendation is that the elderly could sacrifice some of their newly-forgotten gains to help the Reagan Administration reduce its deficits.

The stereotype of the prosperous elderly presented by these articles is as misrepresentative as the stereotype of the pitiable old person. If Congress were to base some of its budget decisions on this misinformation, older people would be harmed. The fact is that, while there are some well-off older people, there are many more who live in or very near poverty. It is only because of Federal programs, in particular Social Security and Medicare, that poverty among the elderly has been drastically reduced. It is these very programs that needlessly being subjected to budget reductions, thereby once again threatening the income security of senior citizens.

Most of the credit for the reductions in poverty among the elderly belongs to Social Security. The program's benefits are indexed to keep pace with inflation, so that the purchasing power of benefits is protected. Without this annual adjustment, the elderly's income would lose stability and value, since few other retirement income sources are updated for inflation.

The very tenuous nature of the older person's economic security and the absolute value of maintaining the purchasing power of Social Security income become apparent when we look at the Cost-of-Living Adjustment [COLA]. One-half million more people aged 65 or over would live in poverty if the Cost-of-Living Adjustment were not granted in 1986, according to a study by Data Resources, Inc. The Congressional Budget Office reported last week that the variation on the COLA cut which the President and Republican Senate leaders advocate would increase poverty among the elderly by between 530,000 and 570,000, depending upon inflation estimates.

Social Security's success in raising thousands of elderly out of poverty is an achievement that all Americans can be proud of and is one to which nearly all working Americans have contributed. We urge Congress to protect the Social Security system, its contributors and its recipients. We ask you to reject the unwarranted and unfair COLA cuts which were proposed in a desperate attempt to reduce the Federal deficit.

We also ask you to recognize that Social Security and Medicare are inextricably linked. The strength and adequacy of both programs determine the economic and health security, as well as the relative independence, of the Nations elderly population. Public policy must not only treat the programs as a unit of support for the elderly, but also recognize that changes in one program can erode benefits in the other. The President's latest budget plan ignore this fact.

The "compromise" budget policy proposed by the President is a destructive combination of attacks on the elderly's health and income security. Beneficiaries' out-of-pocket expenditures required under Medicare will be increased through the raising of the Part B premium and deductible. The value of Social Security benefits will be decreased through cuts in the COLA. The average 5-year Social Security income loss is projected to be $1,257 per beneficiary. The expected increase in Medicare premium costs is projected to be $410 over the same period.

We urge the Committee to consider the individual and the combined impacts of the President's Social Security and Medicare proposals. I will now comment on specific Medicare budget proposals which the National Council of Senior Citizens believes will adversely affect beneficiaries.

The harm of the President's proposals is not only that they would derive about one-third of the Medicare "savings" from beneficiaries, but also that they are a part of an ovrall budget plan which ignores the fiscal and spending imbalances causing the Federal deficit growth. Moreover, the proposals shift or arbitrarily cut spending rather than make changes which would be beneficial to the Medicare program or its recipients.

PROPOSALS

Increase the Part B premium so that beneficiaries pay some of the government's current share of program costs; increase the Part B deductible yearly according to the rate at which physician payment rates increase.

Background

Under these plans, the premium would rise to about $408 by 1990 or 50 percent higher than under current law; the deductible would increase to $78 the first year. By 1990, Part B could cost an aged individual nearly $500 before Medicare will reimburse a penny.

Part B (Supplemantary Medical Insurance) is an insurance plan which today costs the elderly $186 per year in premiums, with a $75 annual deductible. The plan reimburses only about 56 percent of physicians' billings.

Part B program costs have increased over the years primariiy due to price inflation, increased use of services and population aging. The first two factors can be linked to physician practices and incentives created by reimbursement methods.

It is widely recognized that control over program spending cannot occur without prospective payment. The Part A payment reforms testify to Congress' recognition of this fact. Yet Part B outlays are essentially open-ended. (The physician payment freeze may limit payment per unit, but not the number of units of service provided.)

Recent budget reductions which raised the elderly's contributions (through the premium) toward program costs and recent growth in program outlays have dramatically increased costs to the Medicare enrollee. The premium has increased by 62 percent since 1981, from $115 to $186.

In 1984, the elderly paid out of pocket an estimated $17 billion for the Part B mandated premium and deductible, the Part A deductible, co-payments, and physicians' fees in excess of assigned rates.

Between budget cuts which have shifted additonal financial burdens to Medicare beneficiaries and medical inflation which is still growing at faster rates than the CPI, older people now expend a portion of their incomes equal to that before Medicare "protection" was enacted.

Comments

These proposals simply shift Federal costs to the aged. The plans do not control, nor are they a part of a larger plan designed to control Part B expenditure growth through reimbursement reform.

Enacting these plans would not only increase the price of access to physician and out-patient service, it would also increase the financial barriers to that service. Lower-cost alternatives to hospital care and timely visits to physicians may be sacrificed under this plan with Part A costs increasing as a result.

PROPOSAL

Extend for another 12 months the current 15-month freeze on physician reimbursement rates.

Background

Payment levels to physicians and suppliers, frozen at levels established on July 1, 1983, are due to rise on October 1, 1985. Under the proposal, the 1983 levels would prevail until October 1, 1986. Under the current plan, physicians' option to accept assignment is voluntary. Physicians' who sign "participation" agreements (100% assignment) were promised a financial reward when the freeze is lifted.

Comments

The current freeze and a possible extension fail to provide needed reform of physician reimbursement methods under Medicare.

The freeze artificially depresses prices but does not control costs. While prices are fixed, physicians can maintain or increase income by providing more units of treatment or more intensive services. Thus, the total costs to the government and the beneficiary would rise.

Continuing the freeze could discourage physicians from seeing Medicare patients, a totally undesirable outcome of public policy.

If "participating" physicians who signed agreements to accept assignment on all Medicare cases are not excluded or otherwise protected, they cannot be expected to renew their contracts; additional participation should not be expected to occur.

PROPOSAL

Establish a co-payment requirement for home health visits exceeding 20 per year; expected price in FY 1986, $4.80 per visit.

Background

No co-payment is required under either Part A or Part B. Congress discontinued the previous co-payment requirement in 1981 to encourage the use of less costly alternatives to institutional care. This benefit is becoming increasingly important to the elderly since prospective payments to hospitals are shortening the length of stay and expanding the need for followup care.

Comments

As with the proposals discussed above, this plan is simply another way to shift the government's costs to the elderly. If all providers are included in a broad plan of Medicare reimbursement reform, cost growth can be controlled without burdening the beneficiary and with appropriate compensation to the providers.

A co-payment in effect penalizes the Medicare beneficiary for growth in the use of home health care. This trend is related to expected changes resulting from DRGs, a desirable goal of using alternatives to institutional care, and lack of reimbursement reform.

PROPOSAL

Offer vouchers to recipients to buy health insurance in the private market in lieu of Medicare payment for services.

Background

While the Medicare program pays most providers after services are rendered to Medicare patients, payment to health maintenance organizations (HMOs) and other similar plans is made on a per capita prospective basis.

Comments

The new payment method to HMOs offers beneficiaries a significant cost-saving alternative to current Medicare payment policy; a major change such as a voucher is not necessary.

Offering vouchers may be the first step in dismantling the program and allowing the Federal government to relinquish responsibility and accountability for the program.

Additional proposals apparently aimed at providers could reduce health care providers' capacity or willingness to give service to Medicare patients. Specifically, I refer to the provider freezes. The hospital payment freeze would be imposed at the halfway point of implementing the DRG (diagnosis related groupings) program, which is changing hospital reimbursement to a fixed-price basis. Neither the effectiveness of the new plan nor its impact on patients, providers, or quality of care has been fully evaluated. An arbitrary limitation of payment to hospitals and long-term care providers could exacerbate the negative impacts that DRGs are reported to be having on Medicare patients.

Since implementation of DRGs, the length of hospital stays for Medicare patients has decreased; patients are being discharged in greater need of follow-up care. Skilled nursing facilities and home health agencies are reporting an increase in the numbers of very ill persons referred for their services. At a time when Medicare payment rates to these providers need to be adjusted to account for the care of more seriously ill patients, and to ensure the appropriate post-hospital care of Medicare beneficiaries, the payment rate is, in effect, being lowered.

Mr. Chairman, I have focused on the proposals we believe will adversely affect senior citizens. We recommend that these proposals not be enacted. However, we recognize that the Committee is faced with the task of identifying savings. In addition, we believe the Committee members also recognize that certain change in the Medicare program is both warranted and desirable.

Therefore, I make the following comments:

The causes of the Federal deficit and the savings meant to retard its growth should not be sought in the Medicare program. Look at the President's fiscal and spending priorities for the solutions to the deficit problem.

We urge you to seek carefully thought-out savings for Medicare, not arbitrary budget reductions which place beneficiaries at risk and give providers incentives to reject Medicare or "game" the system. This method negates the savings or jeopardizes the health of senior citizens. We have had enough of this method over the last four years.

The entire health care system needs the attention of Congress. We believe that the most desirable and most equitable savings in Medicare will be achieved through health system reform and Medicare reimbursement reform. Long-term savings and equity will not be achieved unless Congress gives providers the incentives toward economic efficiency by placing them at risk in the payment system.

The National Council of Senior Citizens supports the Kennedy/Gephardt proposal, Medicare Solvency and Health Care Incentives Reform Act of 1985. It assures savings without benefit cuts, changes provider incentives, rewards efficiency, and builds a nationwide system of health cost management. We urge the Committee to seriously consider such a plan. If the bill had been adopted in the last session, I think today's hearing would not be looking at the ways to cut Medicare.

In the meantime, we ask you to look at Part B reimbursement reform to control outlays rationally and fairly without penalizing either the providers or the recipients of care.

It is not at all surprising that Part B outlays growth is so, strong: DRGs are shifting costs from Part A to B; out-patient services provide less clearly alternatives to institutionally based care, as the Peer Review Organizations (PROs) recognize; and Part B reimbursement is still open-ended and retrospective. We cannot afford to freeze payments, increase cost sharing, or simply reduce the budget to deal with this growth.

Finally, plans to add new revenues to the Medicare trust funds are frequently discussed as a way to deal with the financing of the program. We urge you to consider that new financing and cost control or incentives for efficiency are not analogous. They may all be necessary at some point, but we suggest that new revenues not be sought without total system cost containment. Otherwise we will simply be adding money to the problem while allowing costs to grow for the same reasons they are today.

I thank you for the opportunity to express the views of the National Council of Senior Citizens.

Chairman **Stark**. Thank you very much.

Ms. Ostrander, in your testimony—I want to be sure that you and I are talking about the same numbers here. Were you talking about the increases for the average retired worker when you use the net loss figure of $1,814, and $3,292, when you were talking about the total cost over the 5-year period; is that correct?

Ms. **Ostrander**. Yes; in other words the CPI minus two and its compounded effect as well as the increase in the part B premium and deductible.

Chairman **Stark**. Thank you.

At first I thought that was per year and that seemed even more foolish than what I was anticipating.

Can you explain to me when you talk about extending the coverage until the month following one's 65th birthday? You say it will create a gap in the coverage? Why won't private insurance fill that gap?

Ms. **Ostrander**. In the experience record of private insurances, that doesn't always work. The month individuals become 65 generally is the curtailment of private insurance.

You have a gap in there for many people, not only workers who reach that age, but you have for some of the poor who have no other insurance to fall back on who may need acute care and have absolutely no insurance.

Chairman **Stark**. OK.

I know we had this problem with the Social Security bill that was led so ably by my colleague, Mr. Pickle, through the legislative thicket some years ago—but it does occur to many of us that we are living longer and healthier and perhaps working longer and that at some point in the long-range scheme of things, extending our working years beyond age 65, which was a number picked out of the air. But that might not be unfair to apply prospectively to younger workers so long as they had enough time to anticipate that in their plans.

By definition of younger, I mean anybody younger than me, just to make it clear—but I wonder where your group would feel opposed if the age eligibility were to be extended on a prospective basis.

Ms. **Ostrander**. Right now we would have to say, yes, we would oppose it because you don't know really what the costs would be for that protection. Plus the fact there is a disincentive for that younger worker who is paying into the system. He would become a little more discouraged about what the future has for them as individuals.

I think right now we don't have enough information to go on and we would not want that emphasis put on there, specifically if we want to retain the support of the younger worker.

I think we need to demonstrate our capabilities of retaining some of those benefits.

Chairman **Stark**. What about some sort of means testing for older Americans?

Ms. Ostrander. Again, I would have to repeat to you, you are going to erode the public support for it. You are going to change Medicare from a social insurance program to a welfare program. It then becomes a political football in Congress, which would benefit no one and we believe this would not be in the best interests of the total public.

Chairman Stark. Do you think we did all of those things in the Social Security reform? It may be too early to tell, but, except from very rich people who don't like paying income taxes on some of their Social Security benefits, I don't think I have heard many complaints.

I have not heard any complaints with younger people who may have to work until they are 67. I may hear that from them when they see that they have a notch effect, if I am still here, but it was, in fact, one of the only ways we could get a compromise, and to bring the much-needed reform to the retirement part of Social Security.

I wonder if you find that there have been in your association any stories of causing real problems with how we dealt with Social Security. Has that impacted aggregiously on your members?

Ms. Ostrander. One of the things is, I know this is the first year that this has gone into effect, and I would have to say if you picked out any one area that we have heard from the members more, it is this issue that we have heard about this year. Both in mail and telephone calls.

Chairman Stark. Which area is that?

Ms. Ostrander. The area of the income taxing of the Social Security benefits. I think that as time goes on you probably will be getting a greater volume of correspondence within your offices as well.

Chairman Stark. That may be but my district isn't wealthy enough.

Ms. Ostrander. So, you are lucky there.

Chairman Stark. No; I am not at all lucky, especially when it comes to fundraising time. I will trade you any time.

Ms. Ostrander. The administrative costs to means test Medicare could outstrip any possible savings that you would have. We believe that has to be looked at. When you talk about dealing in the income tax system, you are going to have to recognize that only 50 percent of the elderly even file a return so, therefore, you have some real problems there.

Chairman Stark. I don't mean to be contentious, but I think it illustrates that if we are going to save money at some point—I think as the testimony goes on today we will see that we are going to have to cut spending and somebody will have to give up something. I also find that our witnesses are perfectly willing to suggest that other folks give up things.

I am merely trying to find areas where, for example, if I can get Congressman Aspin to cut out a nuclear aircraft carrier, or if I could tax cigarettes, the AARP would be willing to give up a little bit as well as meet the overall goal of deficit reduction which probably inures to their benefit.

I am searching as we go along. If you have to have a cut, where would you prefer it?

Ms. **Ostrander**. Right now I can't define that, but, yes, we would be willing to look at the total package, but the total package has to be a fair one and if you recognize that some of the areas that I have mentioned and some of the areas that Congress has very much been aware of that are slipping through without revenues coming in, that should be examined, such as some of the corporations who have not paid income tax for a number of years and have gotten considerable rebates.

I think that we have to see fairness and we have to see it in a total package before we will say specifically which area we would agree to.

But, yes; we are interested in deficit reduction.

Chairman **Stark**. Great, thank you. Thank you very much.

Mr. Clayman, I would ask you, I guess, some of the same questions. If we are going to make some savings at some point, you can only have one end of the teeter-totter in the area at the same time. I am not asking you if it is easier to lower your price than it is to raise it, but are there areas if we are faced with that either in a political compromise or budget compromise, areas that you would have us begin?

Would it be in means testing? Would it be extending the age of eligibility?

Mr. **Clayman**. We don't begin by cutting, Mr. Chairman. That is a prerequisite to most anything that I will say. We don't begin by cutting.

We look toward other alternatives; are there other alternatives? We look to who has been paying the price for cutting so far and the plan fact is that senior citizens have been paying and the expression, as it goes on the street, paying through the nose, $27 billion in Medicare. Billions upon billions in Social Security.

Did we get any beefs? We represent mostly trade union folks who are, I suppose, our middle class in our organization, and others, church people, all the colors, all the shades of religions, poor people, and they have been paying the price and we have received all kinds of beefs although in the interest of compromise that was the spirit of the day when the commission came back with its report.

Chairman **Stark**. You are referring to the Social Security now?

Mr. **Clayman**. Social Security, yes.

Chairman **Stark**. OK.

Mr. **Clayman**. We went along but we were reluctantly going along.

Chairman **Stark**. I, honestly, don't know anyone that went along enthusiastically. I honestly don't. That was the general view of my colleage from Texas. My theory was, if there was anybody in this town smiling the bill failed.

Mr. **Clayman**. If everybody is unhappy, I always look to find what is wrong.

Chairman **Stark**. Well, it was——

Mr. **Clayman**. And when you find everybody is unhappy you must not shout victory.

Chairman **Stark**. That is what we did. If anybody had been smiling you would think they escaped free and that would have been a problem.

Mr. **Clayman**. That is exactly what happened. They felt they were aggrieved, yes; and they had in my judgment, they had reason to be but perhaps it can be said in a very general way, very general way, that maybe something had to be done. But they paid the full price and the workers now who are still not on Social Security, they are paying the full price, and between the sacrifices of all of those including those who could least pay a sacrifice, we somehow muddled through.

But I don't see that happening in Medicare. In Medicare, as I say, $27 billion already has been paid in the first go-around. Here we are the second go-around, a kind of merry-go-round, and the elderly are commencing to feel that they are the donkeys in this parade, that the load is being pressed on their shoulders and I see some of them—I don't see all of them, of course—I see some of them and I sense from what they say at meetings in their frankness that they are hurting.

And I tell you this—and I don't make this as a substantive argument—that it is political dynamite and it will continue to be so because essentially people feel that they have been done upon. As long as this continues, we cannot have a coherent America.

Those are some of the quick thoughts that come to mind in that general question that you asked.

Chairman **Stark**. Thank you.

Mr. Gregg.

Mr. **Gregg**. Thank you, Mr. Chairman.

Mr. Clayman, following up on the chairman's comments, if you could advise me specifically, would your organization support or consider supporting raising the age at which people would be able to opt into Medicare?

Mr. **Clayman**. Are you asking that question of me?

Mr. **Gregg**. Yes.

Mr. **Clayman**. The answer is no.

Mr. **Gregg**. Following up on the second point, would your organization be willing to consider means testing, something along the lines we presently use to tax the Social Security benefits?

Mr. **Clayman**. The answer is no. That is cost shifting really.

Mr. **Gregg**. Ms. Ostrander, you made the point that you feel that this has to be a fair approach, and if it were a fair approach your organization might be willing to support it.

You listed two of the three areas that you feel were not—that we're not addressing fairly, one is tax loopholes, the other is military spending. The third area is the rising cost of interest, which there isn't a heck of a lot we can do about in the shortrun other than get the deficit under control. Hopefully, this will bring down interest rates. As for the first two, wouldn't an across-the-board freeze as proposed by a number of Members on both sides of the aisle, which would include the freezes proposed here in Medicare, be a fair approach?

In that scenario we are talking about cutting defense spending by $24 billion, while only cutting Medicare by about $2.5 billion. The defense cuts would represent about 5 percent of the defense budget, while the Medicare cuts would represent about 3½ percent of the Medicare budget, or reduction in rate of growth would be a more accurate statement. Is that a fair approach, an across-the-board freeze which takes a significant amount more out of the military side than what you have—which is the point you were making?

Ms. **Ostrander**. We will look at it as a package. As Congress moves, whichever direction they go, we will look at it as a package. I think right now I would say if you were to weigh what has been proposed versus your suggestion, there may be some pluses in your suggestion. But right now, I would say we will continue to monitor the debate until we see that there is a really fair package.

We, as all of the members do, we want deficit reduction. But we have got to come back and say you cannot permit some of the size of tax evasions that we currently have to continue while we are continuing to ask the elderly to assume the greater proportion of the cuts. Congress has to face up to that issue. It may not be the most desirable issue, but they must face up to that inability to say fairly to the public, "We are asking you to sacrifice, while we let the others get away without taxation."

Mr. **Gregg**. Well, am I to conclude from your comment then that an across-the-board freeze would be something you would not reject out of hand but would be something you would consider as a fair way to approach the spending side of the budget independent of taxes?

Ms. **Ostrander**. We will have to look on the other side as well as the freeze side. You are not freezing the other side. This is one of the areas I need to keep reiterating. You are talking only about the freeze on spending without consideration of tax loopholes.

Mr. **Gregg**. I take it that is a "no" then?

Ms. **Ostrander**. That is right.

Mr. **Gregg**. On the issue of means testing, I didn't really fully understand your response to the chairman. Is it your position that your group will not accept means testing?

Ms. **Ostrander**. Absolutely. The membership has made that loud and clear. There are too many problems inherent in it including losing public support for the program, destroying its social insurance aspect, the administrative costs which we believe will override any potential savings, as well as the inability to work it into the tax system when only 50 percent of the elderly file income taxes.

Mr. **Clayman**. If I may comment quickly.

Mr. **Gregg**. Certainly. Is it on that point?

Mr. **Clayman**. Generally, yes.

I have said that the answer really is cost containment. I would guess that the better part of sense and politics and integrity demands that we look to that issue before we start to ramble around reaching out in all directions for pieces and hunks that may affect different segments of our society differently.

We have been adamant in our own way that cost containment is the definitive answer as far ahead as we can see. If we make an honest effort in that direction—and we haven't, seriously—if we have made an honest effort in that direction and we fail, then we will have to look for other alternatives, but this is not the time for other alternatives. They are too harsh. Whatever alternative you go to is too harsh.

Mr. **Gregg**. Since we are on general topics, let me just say that I don't consider it too harsh that when the president of IBM retires and the local janitor of IBM retires, the president should have a higher obligation to pay for his medical insurance than the local janitor. As a practical matter, I consider the testimony that you presented here today to be totally inflexible.

How are we to help the elderly in this country if we are not willing to address the issue of the deficit? Because the thing that was probably of most assistance to the elderly over the last 4 years is the significant reduction in inflation rates in the country. The fact is that people who are on a fixed income do not see their checks being chewed up by inflation. We will not be able to continue that if we don't do something about the deficit. If you folks are going to come up and stonewall us and say, "We are not willing to accept any alternative other than the one we have on the table," I don't see how we as a committee will be able to aggressively move forward on an issue that is critical to the retired people in this country.

Mr. CLAYMAN. Let me see if I can make myself understood.

Mr. GREGG. I think you have made yourself understood as far as I am concerned.

Mr. CLAYMAN. All right. Let me say it again.

We believe earnestly—and there are lots of people that believe it with us, not just among the ranks of the elderly—that cost containment, honest cost containment, is the answer. Now then, what you are saying is that apparently it is not the answer and if it isn't the answer, can we now proclaim that we are to go elsewhere?

Mr. GREGG. I don't want to end up in a lengthy debate because there are other people who wish to testify, but there are a number of facets to this problem which we will clearly have to address. One is cost containment, but the others are the question of means testing and some other issues raised by the chairman which I thought were very appropriate.

Chairman STARK. Mr. Pickle.

Mr. PICKLE. Thank you, Mr. Chairman.

This is a hearing on the Medicare issue, but we seem to keep wanting to rehash the Social Security bill of 1983. I therefore, want to make the observation that overall we passed a good and substantial bill and it was necessary. Now, if you don't like the taxing or including half of the Social Security benefits over the threshold, well, that is a form of a means test.

Some of us didn't like that initially, but it became an integral part of the package. It is estimated it will bring in revenues of approximately $29 to $30 billion between now and 1989. Without that in the package, we might not have had a bill.

Now, we are facing the same issues in Medicare, more so perhaps than in Social Security. It is not what you would want. I recognize you have given us what you would rather have. But it seems to me you are being a bit inflexible. I would ask you specifically that if we were to freeze the DRG rates for the hospital and if we were to freeze physicians' payments, why shouldn't we ask Medicare beneficiaries to make some sacrifices, also?

Do you think you should not make any further sacrifices, assuming the freeze on both the other parts?

Mr. CLAYMAN. My judgment is, for whatever it is worth, that the elderly have already paid enough.

Mr. PICKLE. That is not the question. That is not the question.

Mr. CLAYMAN. That is the answer.

Mr. PICKLE. What are we going to do if we are going to solve this problem that would be fair to all parties concerned? You are saying they have paid enough; you don't want to do any more. You paid a little as you went along, your premium increased a little over the years. That is a sacrifice. If we make additional freezes on the others, shouldn't we also expect beneficiaries to make some sacrifices as well?

If you say no, you paid enough, then you are being inflexible.

Mr. CLAYMAN. Well, I will tell you in my judgment it was this kind of inflexibility that made Social Security possible, that made Medicare possible because there were many voices who said it couldn't be done, it shouldn't be done, but it was this kind of inflexibility and insistence that gave birth to those ventures, the greatest social ventures in our century.

Mr. PICKLE. Well, I am asking you——

Mr. CLAYMAN. The question is not my flexibility or inflexibility. It is the sense of the rightfulness——

Mr. PICKLE. Let's put it this way: It is my feeling that we may require flexibility on everybody's part if we are going to get a package. We said at the beginning of the Social Security reform it may take a little hide and a little hair from everywhere and it did. I simply say to you that we may reach that point.

Now you say you are not inflexible. Let me ask you, either one of you, if the Medicare premiums cover 25 percent of program costs today—that is for part B—do you think it is reasonable to maintain that level of participation indefinitely, always keep it at 25-75?

Mr. CLAYMAN. I don't know what the future may ultimately bring, but for the moment, it is sufficient. If we are serious about creating fairness and an efficiency in the delivery of health care.

Mr. PICKLE. You want fairness and efficiency if we keep it at your level? I am not trying to be argumentative, but I am just saying we have to look at all these positions.

Do you want to make a comment, Ms. Ostrander? You look like you are anxious to get into this argument. I would be glad to recognize you.

Ms. OSTRANDER. I think one of the things we have to come back to, we are dealing with deficit reduction here. We are not dealing with Medicare reform.

You have to separate those two out.

As you know, we have supported deficit reduction in what we considered a fair package in the past.

We have said we would again look at it, at a package, but to ask the elderly at this point to assume the greater burden, recognizing that the basic problem on the part B, which you are referring to, is not the premium in itself, but what has been happening in the increase in part B costs, we are not addressing the real structural change that needs to be there.

Before we ask the elderly to assume greater responsibilities, let's go back to what is needed to be done in deficit reduction.

Mr. PICKLE. It is easy to make a deficit reduction argument when you cue your problem to raising cigarette taxes to 32 cents or not spend so much on the MX missile. We could argue all day and night about that. The fact is we have to look at our program and say what is the best way to make it solvent, to give us the best medical care delivery system we can to our people.

I don't think any of us have a plan or that we are determined that any one approach has to be made. But I do say to you that we must have flexibility on everyone's part. That is the only thought I leave with you.

Thank you, Mr. Chairman.

Ms. **OSTRANDER**. We appreciate that, but we mentioned in our statement the need to go after an additional criteria rather than just program savings. I think we have got to look at the whole situation, what are we trying to do?

Mr. **PICKLE**. Are there any circumstances under which you would support a premium increase for beneficiaries?

Ms. **OSTRANDER**. I think we would have to again come back, Congressman—because you know we have not been unreasonable. We have looked at the combined packages in the past and even though not everything was in our agreement, we supported it. We would have to say the same thing here. We would have to take a look at what is in that package besides a premium increase. I don't think we should go after that unless you can show the elderly this go around that other people are also being impacted by deficit reduction. We have too many tax loopholes out there.

Mr. **PICKLE**. I would agree with that statement and I think you have a reason to have some reservation and I want to look at it again and come back to it. The AARP has always been very reasonable. You didn't support all the items in social security, you didn't object to the taxing of benefits, you didn't like it. You accepted with grace the raising of the age, but you supported the package when we got to final passage. You are one of the great organizations in this field and I know you will give us your cooperation and we look forward to working with you again.

Ms. **OSTRANDER**. We certainly will.

Chairman **STARK**. I want to thank the witnesses and I would like to say again, to focus for a moment on this, because, Ms. Ostrander, your comments are well taken. This is not a hearing on reforming Medicare. We are responding to a suggestion by the Office of Management and Budget or whomever works in the strange ways of organizing a budget, to a proposal to save some money.

I am sure that all of us wish that, for whatever reasons, whether it is economic growth or reduction of military spending, we had a lot more money to spend. We have not talked about long-term care and uninsured people, all the wonderful things that I think most of us on this committee believe this country ought to be able to afford. Unfortunately, that is not in the process of the budget proposals. We are faced with having to respond to the budget committees on exactly what will result if we were to in fact accept the freeze and/or cuts, however you want to call it, proposed by the administration.

It may be that in the politics of this organization we may have to suggest some savings of our own and I think that both Mr. Gregg and Mr. Pickle and myself are not unsympathetic to the needs, but we are looking for a way.

I appreciate your patience with us as we try and wander through this, but it is going to be a difficult compromise where there isn't enough. In the days of plenty, why, it's great fun, but in the days of cutting, it is no fun at all and we appreciate both you and Mr. Clayman taking the time to present your views. We look forward to working with you as this package builds over months ahead.

Thank you very much.

Ms. OSTRANDER. Thank you.

Mr. CLAYMAN. Thank you.

Chairman STARK. Our next panel consists of Dr. Harrison Rogers, president-elect of the American Medical Association; and Barbara Hatcher, immediate past president of the DC Nurses Association.

Welcome to the committee.

Dr. Rogers, we have your statement in its entirety. Without objection, it will appear in the record. If you would care to summarize or amplify in any way, you may proceed at this point.

STATEMENT OF HARRISON L. ROGERS, JR., M.D., PRESIDENT-ELECT, AMERICAN MEDICAL ASSOCIATION ACCOMPANIED BY BRUCE D. BLEHART, J.D., ASSISTANT DIRECTOR, DEPARTMENT OF FEDERAL LEGISLATION

Dr. ROGERS. Thank you, Mr. Chairman.

I am Dr.——

Chairman STARK. If I could interrupt just a moment. In the age of high technology here, the Ways and Means Committee was passed by. You have to practically swallow these microphones for the reporter and members of the audience to hear. If you would keep that in mind, I am sure people would appreciate it.

Thank you very much.

Dr. ROGERS. Thank you, Mr. Chairman.

I am Dr. Harrison Rogers of Atlanta and with me is Bruce Blehart from our staff.

The American Medical Association is concerned that the series of proposed cuts continues the practice of the last 5 years to target Medicare for an inequitable burden of Federal spending reductions. Further cuts in Medicare will harm those who can least afford it, erode the quality of health care, jeopardize access to physicians and other providers of health care, and unfairly shift costs to other segments of society.

With a progam as important and complex as Medicare, we believe that modifications should not be viewed within the context of individual budget cuts solely designed to meet arbitrary standards. Instead, they should be viewed in the broader context of providing health care for the elderly and disabled today and well into the next century.

At this time, the Association is studying proposals that would utilize new concepts to change funding for health care for the elderly from the current pay-as-you-go program to a self-funded system where resources will be set-aside to provide real trust funds for the future. We believe that such a program will be workable and is essential if the Nation is serious about ending the annual budget crises in health care programs.

The AMA opposes continuation of the freeze on Medicare reimbursement and physician fees. We support an appropriate increase for Medicare physician and hospital reimbursement as now provided by law, unless the Congress legislates an across-the-board freeze of domestic and defense spending as part of a broad program to reduce the Federal deficit and bring stability to the economy. Absent such an across-the-board freeze, the AMA does not believe it appropriate for Medicare to bear the brunt of efforts to hold the line on governmental spending.

In the last congressional budget cycle, the only freeze imposed was on physicians. Continuation of the freeze would extend an unfair and extremely discriminatory practice. An extension of the freeze would be particularly discriminatory as only physicians would be subjected to a 2-year freeze.

Under the Deficit Reduction Act of last year, the increase in the Medicare prevailing rate scheduled for July 1, 1984, was eliminated, and the July 1, 1985 increase was postponed. A continuation of this action will mean that there would be no allowed increase from July 1, 1983 through September 30, 1986—a 39-month freeze. Moreover, because of Medicare's payment structure, reimbursement for most of 1986 will be based on 1982 charges.

A continuation of the reimbursement freeze under Medicare, on top of the already low level of Medicare reimbursement for physician services, could have a number of unfortunate results. A continuation of the freeze will not only discourage physicians from accepting assignment, it will discourage physicians from treating Medicare beneficiaries, and for those physicians who continue to treat Medicare beneficiaries, it will reduce their ability to acquire new equipment and adopt new technologies.

The rate of assignment of all claims has increased steadily from 50 percent in 1976 to 67 percent in February of this year. We are concerned that a continuation of the Medicare reimbursement limitations and the fee freeze will discourage physicians from accepting Medicare claims on an assigned basis. The ability of physicians to accept assignment on a claim-by-claim basis is an important element of Medicare that assures beneficiaries access to virtually any physician.

The current freeze has already resulted in some physicians finding it difficult to continue treating Medicare beneficiaries. This has resulted in a break in valuable physician/patient relationships. A continuation of the reimbursement limitations and the fee freeze can only exacerbate these problems. This particularly will be true for those physicians who held the line on their fees during the AMA voluntary fee freeze last year. These physicians will be penalized for their act of voluntarily freezing fees.

Mr. Chairman, continuation of the freeze represents a major step away from accomplishing the goals of the Medicare Program to assure access and quality care for the Nation's elderly and disabled.

In addition, the American Medical Association opposes the reductions in graduate medical education funding proposed in the President's budget. We are particularly concerned over the proposed-50 percent cut in indirect medical education costs. Many inner city teaching hospitals that provide substantial amounts of care to the poor would be severely affected. We also believe it is premature to alter hospital reimbursement until sufficient data is available concerning the impact of the recently implemented PPS. This is particularly true in light of a fundamental flaw in the DRG system—the failure to reflect severity of illness and case-mix differentials.

The AMA believes strongly that an in-depth study of the financing of graduate medical education should be undertaken before Congress considers major changes. To this end, the AMA has established an ad hoc committee which will conduct a thorough study of the financing of graduate medical education.

In conclusion, Mr. Chairman, the American Medical Association urges this committee to again consider that actions taken concerning cuts in the Medicare Program will have an impact well beyond the fiscal year 1986 budget and the growing deficit.

Thank you very much.

[The prepared statement follows:]

STATEMENT OF HARRISON L. ROGERS, JR., M.D., PRESIDENT-ELECT, AMERICAN MEDICAL ASSOCIATION

Mr. Chairman, and members of the committee, my name is Harrison L. Rogers, Jr., M.D., and I am a physician in the practice of general surgery in Atlanta, Georgia. I am also the President-Elect of the American Medical Association. Accompanying me today is Bruce Blehart of the AMA's Department of Federal Legislation.

The American Medical Association is pleased to have this opportunity to appear before this Committee to address our concerns over proposed budget cuts in the Medicare program. While some of the Administration's Medicare budget proposals for fiscal year 1986 warrant support, the series of proposed cuts to the Medicare Program continue the practice of the last 5 years to target Medicare for an inequitable burden of Federal spending reductions. Further major cuts in Medicare will harm those who can least afford it, erode the quality of health care, jeopardize access to physicians and other providers of health care, and unfairly shift costs to other segments of society.

The American Medical Association appreciates the difficult decisions that this committee is facing. Indeed, you are facing a true dichotomy. On one side there is the need to find savings in the Federal budget and on the other side is the responsibility to assure the availability of high quality health care services for the Medicare population.

Mr. Chairman, let me assure you that physicians are continuing to provide high quality services to Medicare beneficiaries and the rest of the population—even in the face of decreasing Federal reimbursement and rapidly rising expenses in insurance and other practice costs. In addition, physicians are committed both to holding the line on health care costs and to assuring the availability of high quality health care services.

The AMA is strongly committed to restraining health care expenditures. In response to an AMA call to all physicians in February 1984, physicians voluntarily agreed to freeze their charges to all patients, not just Medicare beneficiaries, for a 1-year period. Approximately 80 percent of the Nations's physicians participated in the freeze, resulting in an estimated savings of nearly $1.5 billion dollars that otherwise would have been spent for physicians's services. The voluntary freeze was a significant factor in the recent slowdown in the rate of increase in the cost of physician's services. The AMA is continuing to urge physicians to consider each patient's financial needs when setting charges and to accept Medicare assignment, reduce fees, or charge no fee at all in financial hardship cases.

Mr. Chairman, in our comments we are addressing only those items of the Administration's FY86 Medicare budget proposals that were raised in the Committee's press releases. We are opposed to the budget proposals that ultimately may have the most significant negative ramifications among Medicare beneficiaries. As pointed out in the attached report, the AMA supports major structural reform of the Medicare program. We believe, however, that some modifications also discussed in this report are essential to assure adequate time for the development and consideration of long-range solutions for the Medicare program.

NEED FOR LONG-RANGE ANALYSIS AND SOLUTIONS

In each of the last five years Congress has passed a series of cuts in the Medicare program, as part of the Omnibus Budget Reconciliation Act of 1980, the Omnibus Budget Reconciliation Act of 1981, the Tax Equity and Fiscal Responsibility Act of 1982, the Social Security Amendment of 1983, and the Deficit Reduction Act of 1984. The American Medical Association does not believe that continued Medicare funding cuts are appropriate. While it is clear that Congress must deal with the proposals in the President's budget, the continuing heavy cuts in this program have changed its direction without adequate analysis of the impact of these changes on program beneficiaries. With a program as important and complex as Medicare, we believe that modifications should not be viewed within the context of individual budget cuts solely designed to meet arbitrary "savings" figures. Instead, they should be viewed in the broader context of providing health care for the elderly and disabled today and well into the next century. Even though the date of predicted insolvency for the Medicare Hospital Insurance Trust Fund has just recently been set back to 1998, there can be no doubt that this program needs substantial modifications to avoid bankruptcy in the future. Congress should address the long range viability of the program.

The American Medical Association has taken a lead role in looking for long-range solutions to today's and tomorrow's health problems. In 1982, we initiated the Health Policy Agenda for the American People project to develop a philosophical and structural framework to aid in developing future health policy that will assure the availability of high quality health care services of the American people. The AMA has committed over $3 million to this project which involves over 150 organizations including representatives of medicine, government, nursing, labor, business, the hospital industry, health care payors and the public. Along with this program we are also looking for long-range solutions to the problems concerning the impending bankruptcy of the Medicare program.

The American Medical Association has recently issued two major reports on the Medicare Program. The first report set out the development of the Medicare Program, reviewed the financial crisis the program is facing, and identified a series of proposals that should be considered to assure solvency of the program for the short term. The second report (attached to this statement) sets forth a series of options for reform of the Medicare Program. At this time, the Association is studying proposals that would utilize new concepts to change funding for health care for the elderly from the current pay-as-you-go program to a self-funding system where resources will be set aside to provide real trust funds for the future. We believe that such a program will be workable and is essential if the nation is serious about ending the annual budget crises in health care programs.

Congress has made a commitment that health care needs of the elderly will be met. We are concerned that continued annual cuts in Medicare will result in this promise being broken. We are committed to the development of a rational proposal to aid the nation in fulfilling its obligation to the elderly of today and the future.

THE ADMINISTRATION'S BUDGET PROPOSALS

The two major features in the Administration's budget proposal for Medicare savings involve a freeze in the reimbursement level for hospital services and a continued freeze on both maximum program reimbursement and actual fees for physicians' services provided for Medicare beneficiaries.

The AMA opposes continuation of the freeze on Medicare reimbursement and physician fees. We support an appropriate increase for Medicare physician and hospital reimbursement as now provided by law, unless the Congress legislates an across-the-board freeze of domestic and defense spending as part of a broad program to reduce the federal deficit and bring stability to the economy. Absent such an across-the-board freeze, the AMA does not believe it appropriate for Medicare to bear the brunt of efforts to hold the line on governmental spending.

CONTINUATION OF THE PHYSICIAN FEE AND REIMBURSEMENT FREEZE

The American Medical Association is opposed to a continuation of the freeze on physician reimbursement and fees under Medicare. In the last Congressional budget cycle, the only freeze imposed was placed on physicians. Continuation of the freeze would extend on unfair and extremely discriminatory practice. Other elements of the economy are not being asked to undergo similar restraints in payment from the federal government. An extension of the freeze would be particularly discriminatory as only physicians would be subjects to a 2-year freeze.

Under the Deficit Reduction Act of last year, the increase in the Medicare prevailing rate scheduled for July 1, 1984 was eliminated, and the July 1, 1985 increase was postponed until October 1, 1985. A continuation of this action will mean that there would be no allowed increase from July 1, 1983 through September 30, 1986—a 39-month freeze. Moreover, because of Medicare's payment structure, reimbursement for most of 1986 will be based on 1982 charges. Although inflation has abated since the double-diget levels of the late 1970's, the proposal to continue the freeze for an additional year will only lengthen the already substantial time lag in reflecting changes in reimbursement.

A continuation of the reimbursement freeze under Medicare, on top of the already low level of Medicare reimbursement for physician services, may prove to be counterproductive. Such an action could have a number of unfortunate results. A continuation of the freeze will not only discourage physicians from accepting assignments, it will discourage physicians from treating Medicare beneficiaries, and for those physicians who continue to treat Medicare beneficiaries, it will reduce their ability to acquire new equipment and adopt new technologies.

Acceptance of assignment

We are concerned that a continuation of the Medicare reimbursement limitations and the fee freeze will discourage physicians from accepting Medicare claims on an assigned basis. This could reverse the current trend of continually increasing rates of assignment. The ability of physicians to accept assignment on a claim-by-claim basis is an important element of Medicare that assures beneficiaries access to virtually any physician. The history of physician acceptance of assignment bears out the fact that physicians do recognize the financial needs of their elderly patients and that they do accept assignment where warranted.

Continuing a trend started in 1976, the rate of assignment of all claims has increased from 50.5% in 1976 to 67.8% in February of this year. Clearly, we are at a point where those Medicare beneficiaries in need of health care services at reduced fees readily should be able to find a physician who will accept Medicare assignment.

Discourage treatment of Medicare beneficiaries

The current freeze imposed on physician reimbursement along with the freeze on increases in physician fees have already resulted in some physicians finding it difficult to continue treating Medicare beneficiaries. This has resulted in a break in valuable physician/patient relationships as these patients have been forced to seek their care from others. A continuation of the reimbursement limitations and the fee freeze can only exacerbate these problems. For many physicians, accepting Medicare assignment and even treating Medicare beneficiaries in the future will only be done at an economic loss. This particularly will be true for those physicians who held the line on their fees during the AMA voluntary fee freeze. These physicians are now facing a situation where they are to be penalized for their act of good faith in voluntarily freezing fees. A continuation of the freeze can only continue to hit hardest those who have tried to hold the line on increasing health care costs.

Mr. Chairman, the American Medical Association urges this Committee to reject the Administration's proposal to continue the physician reimbursement limitations and fee freeze under Medicare. Continuation of the freeze will fail to achieve its purpose in reduction of Medicare expenditures, and it will be a major step away from accomplishing the goals of the Medicare program to assure access and quality care for the nation's elderly and disabled.

FREEZING PAYMENT RATES TO HOSPITALS

The AMA is also opposed to the proposed freeze in hospital reimbursement for services provided Medicare beneficiaries. The imposition of such a freeze mid-way through the phase-in process of the prospective pricing system [PPS] would be particularly damaging to the quality of health care services.

When Congress created the PPS as part of the Social Security Amendments of 1983, the program was advocated as a way to provide hospitals with incentives to provide appropriate yet economical services. For the first 2 years of its operation, the PPS system was supposed to operate under a requirement of budget neutrality, and increases in reimbursement rates would be allowed to reflect the increase in a market basket index plus 1 percent, with the one percent allowance reflecting the need to make new technologies available. However, even before completion of the first year of the phase-in, Congress has made a substantial change in this reimbursement scheme. The Deficit Reduction Act of 1984 reduced the rate of increase to market basket plus 0.25 percent for fiscal years 1985 and 1986.

The AMA believes that a freeze on further reimbursement cuts would be ill advised and would compromise the ability of the health care system to meet the needs of the elderly. Because the PPS transition period is based on the individual hospital's fiscal year, the PPS has, for many hospitals, not even been in operation for a full year. Already, some institutions are being particularly hard hit by the reimbursement limitations imposed by this system. These difficulties will only get more severe, as the phase-in period is completed and each hospital is increasingly affected by the PPS and its shifting "promises."

MEDICARE REIMBURSEMENT FOR GRADUATE MEDICAL EDUCATION

The Administration's fiscal year 1986 budget proposes to reduce Medicare reimbursement for teaching hospitals' direct medical education costs to the levels that prevailed during hospital accounting periods ending in calendar year 1984. The President's budget also would cut indirect medical education payments by 50 percent.

The AMA opposes the reductions in graduate medical education funding proposed in the President's budget. We are particularly concerned over the proposed 50 percent cut in indirect medical education costs. Many inner-city teaching hospitals that provide substantial amounts of care to the poor would be severely affected. We also believe it is premature to alter hospital reimbursement until sufficient data is available concerning the impact of the recently implemented PPS. This is particularly true in light of a fundamental flaw in the DRG system—the failure to reflect severity of illness and case-mix differentials.

The AMA believes strongly that an indepth study of the financing of graduate medical education should be undertaken before Congress considers major changes. To this end, the AMA has established an Ad Hoc Committee which will conduct a thorough study of the financing of graduate medical education.

DELAY IN THE INITIAL DATE OF ELIGIBILITY FOR MEDICARE

Under existing law, a person is ordinarily covered by Medicare on the first day of the month in which he or she reaches the age of 65. The Administration proposes that eligibility for Medicare be deferred to the first day of the month following an individual's 65th birthday.

In recognition of the fact that there is a need to achieve budget savings in the Medicare program, the Association supports this proposal. Such a modification in the date of eligibility for Medicare benefits should not result in Medicare beneficiaries facing uncovered costs as most existing health insurance policies provide coverage until the date when Medicare coverage begins.

MEDICARE AS SECONDARY PAYOR FOR WORKING BENEFICIARIES OVER AGE 69

The Medicare Program currently provides that working beneificiaries and their spouses up to age 69 have the option of keeping employment-based health insurance as primary health care coverage, with the Medicare program providing secondary coverage. The new proposal would extend this option for Medicare beneficiaries over age 69.

The American Medical Association supports this proposal. The ability to maintain health care coverage under an employment-based policy will provide continuity of care. Also, as such an extension is optional for the Medicare beneficiary, individuals will not lose any of their rights under this proposal.

INCREASING THE PART B PREMIUM AND DEDUCTIBLES

The Administration's proposed budget calls for gradual increases in the Part B premium so that it will cover 35 percent of Part B program costs by 1990. In addition, the proposal calls for increasing the Part B deductible based on the rate of increase in the Medicare economic index.

The AMA supports increasing the Part B premium and deductible to cover 35 percent of total program costs. Such an action is in keeping with the original intent of the Medicare program. Originally, the program was to be funded one-half by general revenues; however, general revenues now fund approximately three-fourths of the Medicare Part B program.

Medicare, like insurance programs, should have appropriate front-end copayments and deductibles. We recommend, however, that rather than tying the indexing of the Part B deductible to the Medicare economic index, this deductible should be tied to the medical care component of the Consumer Price Index to reflect more accurately changes in the costs of medical services. Also, increases in the Part B premium and deductible should be structured to reflect financial resources of Medicare beneficiaries.

Copayments for home health visits

The Administration's budget proposal calls for copayments for home health visits after the first 20 such visits. These copayments would be equal to one percent of the hospital deductible.

The AMA supports this proposal which would encourage appropriate consumer awareness of health care costs. We believe that reasonable coinsurance amounts will not deter beneficial usage of this valuable health care service. In addition, the fact that the copayment would not be applied to the first 20 home health visits will assure that individuals will not be deterred from early utilizing a health benefit that in many instances can prevent the need for costlier services at a later date.

CONCLUSION

Mr. Chairman, the American Medical Association urges this Committee to consider that actions taken concerning cuts in the Medicare program will have an impact well beyond the FY 1986 budget and the growing deficit. It is important to keep in mind that the Medicare program provides health care services that are necessary and appropriate for over 30 million people, and proposals under consideration by this Committee will set program direction for years to come.

Medicare beneficiaries are entitled to high quality health care services. We are concerned that budget proposals will have an adverse impact on the ability of physicians, hospitals and others to assure Medicare beneficiaries the quality of services they were promised.

[Attachment]

[Report: 0 (I-84)]

REPORT OF THE BOARD OF TRUSTEES

Subject: Report on the Medicare Program: II.
Presented by: John J. Coury, Jr., M.D., Chairman.
Referred to: Reference Committee A (Michael P. Levis, M.D., Chairman).

INTRODUCTION

As requested by the Board of Trustees, the Council on Legislation and the Council on Medical Service have continued to review the Medicare program for the purpose of recommending appropriate modification of Association policy concerning the program and the financing of health care for the elderly. In April 1984, the Councils developed and the Board approved a series of guidelines for the overall review of the Medicare program and a series of recommendations that, if adopted, would assure the solvency of the Medicare program through at least the next decade. Board of Trustees Report LL, based on the Councils' recommendations, was submitted to the House of Delegates and adopted at the 1984 Annual Meeting.

Report LL discussed the development of the Medicare program over the past quarter of a century. The report also reviewed the financial crisis facing the Medicare program—the fact that the Part A program was predicted to become bankrupt in the next decade—and identified the factors that are driving the program to insolvency. Report LL set out a series of proposals that AMA will use as a basis for Association action to assure the fiscal solvency of the Part A trust fund for at least the next decade. The report also indicated the Board's intention to continue analyzing the provision of health care services for the elderly and disabled, and the desirability and practicality of substantial further modifications to the Medicare program.

This report summarizes the results of the Board's analysis of the feasibility of an approach combining a modified Medicare program with private sector options to assure health care services for the elderly and disabled.

GUIDELINES FOR REVIEW OF THE MEDICARE PROGRAM

Report LL contained guidelines that were developed to provide a basis for the Board's review of available options concerning the Medicare program. As noted in Report LL, these guidelines impact on one another and they should, accordingly, not be evaluated individually but rather must be considered as a whole to determine whether proposals for programmatic modifications are appropriate. The guidelines are as follows:

1. Access to quality health care for the elderly and the totally disabled through Medicare should be assured. Responsibility for access should be shared by the federal government, the states (e.g., through Medicaid), providers, and beneficiaries.

2. The program should be on a fiscally sound basis to meet present and future needs in order to maintain access to quality care for Medicare beneficiaries.

3. All beneficiaries under Medicare should have access to the same range of program benefits, and should share in the program's cost in a way which encourages responsible use of medical resources. There should be a cost-sharing limit to protect the patient from catastrophic medical expense.

4. Medicare should provide payment for necessary medical services. It should be sufficiently flexible to make appropriate accommodations for new medical therapies and new technology. Expansion of benefits other than for medical services should not divert Medicare resources.

5. Medicare should assure freedom of choice of physician, provider, or system of health care delivery.

6. Medicare should encourage delivery of services in cost-effective settings consistent with appropriate quality of care.

7. Medicare should meet its obligation to pay its full share for promised benefits. Payment for services should be sufficient to assure reasonable access to those services. Physicians should consider accepting, as payment in full, the Medicare approved amount of charges [1] for those beneficiaries for some additional payment would be a hardship.

8. Congress should periodically alter the age of eligibility to recognize changing trends in terms of employment, health status, and longevity of our citizens.

9. Medicare, along with other insurers and payors of medical care services—all of whom benefit from the medical education system—should continue to support medical education.

10. Medicare eligibility should not be expanded beyond the categories (age, disabled, end stage renal disease currently recognized in the law.

11. Cost-sharing based on ability to pay may be considered when administratively feasible and necessry to ensure the fiscal integrity of the program.)

In reviewing these guidelines, the Councils and the Board believe that they provide an appropriate and comprehensive framework for analysis of both short-term and long-term options relating to health care for the elderly. The Board envisions that substantial elements of a modified Medicare program would be retained as a framework for any proposed program of health care for the elderly.

BASIC POLICIES FOR MEDICARE REFORM

The Board believes that basic policy for long-term reform of the Medicare program should (a) assure access to quality health care services for program beneficiaries; (b) allow for a greater range of individual choices of potential options for participation in the modified Medicare program; and (c) assure the solvency of future programs. The Board and Councils believe that a program incorporating the best features of a Modified Medicare program with new private sector approaches will appropriately meet the health care needs of the elderly and disabled for both the short term and long term.

OPTIONS FOR MEDICARE REFORM

At the outset of their deliberations, the Councils considered and rejected three options:

Maintain the Medicare program with no change.—With the projected future bankruptcy of Insurance Trust Fund, this option was rejected by the Councils. The Board believes that it would be irresponsible for the Association to stand by without offering constructive alternatives to the existing program.

Terminate the Medicare program with no special provisions for the elderly and disabled.—Ths option would have the effect of eliminiating government's share of the responsibility for assuring access to health care for the elderly and the disabled. The Board was concerned that major gaps in services could develop for those individuals who would not be able to provide their own coverage.

Maintain the Medicare program with modifications in existing financing mechanisms, but with no change in benefits, payment mechanisms, or eligibility standards.—While the Councils and the Board believe that there is a need to modify the financing mechanism for the Medicare program, they did not believe that simply increasing revenue into the existing system without any other changes would be adequate. With the projected increases in the population of potential Medicare beneficiaries, this approach was seen as being little more than a stop-gap measure that would fail to address fundamental problems in coverage and benefit structure or to meet the three goals set out above of long-term guarantees of access to quality care, choice, and solvency.

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[1] "Approved amount" is synonymous with and replaces the term "reasonable charge" previously used by the Medicare program, and recognizes the beneficiary's obligation for coinsurance.

The Councils then addressed the following four additional broad policy alternatives concerning health care for the elderly and disabled, and selected the fourth as being most appropriate.

Replace the Medicare program entirely with tax incentives to encourage purchase of private insurnace by the elderly and disabled, but continue federal and/or state financial assistance to the needy, elderly and disabled.—While the Councils found elements of this option attractive, they also identified some significant potential drawbacks.

Questions were raised concerning the willingness of the private insurance industry to market private coverage to the Medicare population and the potential for a substantial number of the elderly and disabled to fail to purchase private coverage, or to have to impoverish themselves to be eligible to receive government assistance for health care services. The Councils were also concerned that a lengthy transition period would exist where individuals would still have to devote substantial resources to cover existing obligations and to provide sufficient time for funds to be accumulated so that the elderly could purchase private coverage. Accordingly, the Councils and the Board rejected this option.

Replace the Medicare program entirely with a new combined Federal-State program.—While this option appears superficially attractive, the Councils noted that it would probably present many of the same types of problems experienced with the present Medicaid program. It was noted that there is a tremendous range in the availability of health care services under the existing State-Federal Medicaid program. For example, 31 types of health care services are covered in one state (Minnesota), but only seven types of health care services are covered in another State (Wyoming). Furthermore, states with large numbers of elderly could experience severe financial problems without assurances of adequate federal participation and safeguards. Accordingly, the Councils and the Board rejected this option as impractical.

Replace the Medicare Program with a completely new Federal program.—The Councils gave serious consideration to discarding totally the existing Medicare Program and starting again with a new federal program to finance health care services for the existing Medicare population. However, the Councils noted that any new federal program adopted by the Congress might be of a type—such as a government health service—that would severely limit access and choice (e.g., a government health service). Accordingly, the Councils and the Board also rejected this proposal.

Maintain a modified Medicare program with changes in benefits, payment methods, eligibility, and financing, integrated with private sector approaches.—The Councils and the Board believe that this is the option which should be pursued at the present time. The Board also believes that fundamental modifications must be made in the above four major aspects of the Medicare program if its future is to be assured. In its Report LL (A-84), the Board has already recommended, and the House adopted, a number of modifications in these four elements. Such a modified Medicare program with private sector approaches has significant potential for assuring access to quality care for beneficiaries, and allowing these beneficiaries to seek the health care providers of their choice in meeting their health care needs. In addition, private sector approaches of the nature described in the next section could be combined with such a modified program.

FUTURE HEALTH CARE COVERAGE FOR THE ELDERLY AND DISABLED

In determining long-term proposals, the Board took note of the many changes rapidly occurring in the environment in which health care is being delivered. Fundamental changes in health benefit plan design, health delivery systems and reimbursement are occurring at a rapid rate, and recommendations concerning these broader changes are not at this time being proposed. Furthermore, pressures for mandatory assignment under the current program, and increased competition, will impact on any future programs. Also noted was the existence of separate basic coverage for the elderly, with widespread purchase of Medigap policies to provide extended coverage, including coverage for deductibles and coinsurance.

Based on their review, the Councils and the Board conclude that the most realistic approach to assuring health care coverage for the elderly and disabled is the development of an approach based on a modified Medicare program incorporating substantial changes in eligibility criteria, benefits, and financing mechanisms, combined with elements of private sector approaches. None of these private sector approaches in the Board's view constitutes a viable substitute for the current program in its entirety. However, the Board believes that elements of these approaches can be incorporated into a modified program of health care coverage for the elderly and disabled in such a way as to maximize private sector involvement in the provision of health care services for this population.

Medicare modifications

To achieve this desired goal, the Medicare program would be restructured along the lines concurred in by the House of Delegates in adopting Report LL. These modifications would include:

1. A moderate one-time increase in the payroll tax rate on employers and employees;
2. An increase in the present tax rates for alcohol and tobacco products with the additional revenues from these new taxes directed to the Hospital Insurance Trust Fund;
3. Imposing the health insurance tax on the non-wage income of individuals on non-wage income above a certain threshold and up to the taxable maximum;
4. Imposing a Part A premium on Medicare beneficiaries based on beneficiary income that is above a certain level;
5. Imposing a coinsurance requirement on beneficiaries for Part A hospital expenses up to a specific cost-sharing limit, with the cost-sharing amount to vary according to beneficiary income status;
6. Periodically increasing the age of Medicare eligibility to reflect changes in longevity, health, and employment status, with special consideration given to the coordination of eligibility dates for Medicare and Social Security cash benefits, and to the assurance of mechanisms to continue private health insurance coverage for those who retire prior to attainting Medicare eligibility due to age; and
7. Increasing the Part B premium to a level adequate to fund 35% of program costs, with consideration to be given to relating the premium amount to the income status of beneficiaries.

While these modifications were proposed as "interim" proposals in Report LL, the Councils and the Board believe that such proposals can be structured to achieve desirable long-term results. For example, the proposals relating to means-testing and adjusting the eligibility age under the program could have significant long-term impact on the program over the foreseeable future.

Private sector approaches

Health Individual Retirement Accounts [HIRA].—This concept would adapt the Individual Retirement Account concept into a savings program designed to generate a fund to be used for health care needs by eligible individuals, to supplement or supplant Medicare coverage. Such a program should include: incentives for investing in such an account; stipulations on the use of account funds and coordination of these accounts with Medicare benefits; transition provisions; ultimate disposition of unused funds.

The Councils have met with proponents of "health individual retirements accounts" for discussion of specific proposals of this type. While details of the proposals vary, the general health IRA concept calls for workers to pay into private savings accounts. The funds contributed would generate a tax benefit (credit or deducation) at the time of contribution with tax deferred on interest earned over the life of the account. Upon a person's retirement, his health IRA funds could be used either to purchase private health insurance or to pay for medical care directly. For retirees with such health IRA accounts, the role of the federal government could be limited to providing catastrophic coverage based on ability to pay.

The Councils and the Board view health IRAs as a promising long-term alternative for certain segments of the population. However, they recognize a number of problems which need to be addressed in this approach, including, an extended, phase-in period to allow sufficient funds to accumulate; in a voluntary system, 100% participation would be unlikely; difficulty in predicting the amount of contributions needed to fund post-retirement health care expenses; and the burden of dual contributions for Medicare and health IRAs.

Vouchers.—A modified Medicare program could provide beneficiaries a voucher amount that could be used in tandem with other resources for health care.

This voucher concept, based on the purchase of private insurance, offers certain additional positive features, including a predictable and controllable cost to the federal government; potential for beneficiary choice of practitioner or system; and increased efficiency through competition. In addition, the voucher would permit the beneficiary to purchase coverage integrating basic, supplemental, and catastrophic coverage with appropriate incentives for utilization.

However, a free-standing voucher system is not without problems, the greatest of which may be adverse risk selection. Policies offering the highest benefits are most likely to attract beneficiaries with the greatest need for health care. This adverse risk selection would result in increased premiums above what would be expected from normal actuarial predictions. Thus, such a plan would no longer be competitive for reasons unrelated to programmatic efficiency. Beneficiaries selecting such coverage will bear a disproportionate premium burden relative to low-risk beneficiaries who elect less comprehensive coverage. Additional problems could include the cost of marketing health insurance plans; government oversight and potential regulation; private sector utilization controls on providers; and difficulty in development of voucher amount in light of variation in regional costs.

Employment-Based Health Insurance.—Under this concept, incentives could be developed to encourage employers to provide for supplementary health insurance coverage to retirees who are Medicare-eligible. Such coverage could be provided through corporate contributions to an Individual Health Retirement Account [IHRA], a health retirement funding program similar to corporate pension plans, or through inclusion of such coverage in the employment-based health insurance program. In situations where the employment-based health insurance program is utilized for a Medicare beneficiary, these benefits could be combined with the Medicare coverage in such a way as to allow companies to provide this coverage at the same cost as for younger employees, while at the same time offering a savings to the Medicare Program.

Problems also exist in implementing this approach, including the disincentive for employing older workers, difficulties for small business, or gaps in coverage for employees due to bankruptcy, job changes, and unemployment.

CONCLUSION

The Councils and the Board of Trustees conclude that an appropriate mix of modifications in the current Medicare program with the combined selected private sector approaches of the nature discussed herein offer the best opportunity of assuring availability of health care services for the elderly and disabled over the long term.

Chairman **Stark**. Thank you very much, Doctor.

Ms. Hatcher, we have your statement, I believe, and if you would like to summarize it or expand on it in any way you see fit, your full statement will appear in the record, and you may proceed in any way that you are comforable with.

STATEMENT OF BARBARA HATCHER, R.N., MPH, IMMEDIATE PAST PRESIDENT OF DISTRICT OF COLUMBIA NURSES' ASSOCIATION, AND MEMBER, CABINET ON NURSING, AMERICAN NURSES' ASSOCIATION, ACCOMPANIED BY THOMAS NICKELS, LEGISLATIVE DIRECTOR AND COUNSEL

Ms. **Hatcher**. Good afternoon, I am pleased to appear on behalf of the 188,000 members of the American Nurses' Association to offer our view on the administration's proposed medicare budget for fiscal year 1986. Appearing with me today is Thomas Nickels, ANA legislative director and counsel.

Within the past few years, the Federal Government has moved affirmatively to address the serious financial concerns facing the solvency of Medicare's Hospital Insurance Trust Fund. While no one will argue that fiscal constraint in health care delivery is necessary, we are deeply concerned about some of the resulting effects.

We must bear in mind that at stake are the more than 30 million aged and disabled who depend on medicare to meet their health care needs.

Within the concept of controlling health care costs, we must submit the following principles:

First, the combined effects of new payment policies and delivery mechanisms are altering the practices of providers, and having a significant effect upon patients. We are especially concerned that, in this increasingly competitive market, the needs of our most vulnerable citizens, the elderly, may be overlooked because of the intense focus by providers on the economic bottomline.

We are disturbed that our commitments to the case of the elderly may be harmed by an unrelenting pursuit of cost savings. Any cost containment policy must include a commitment that no member of our society shall be adversely affected by that policy.

Second, Medicare fails to address the long-term health care needs of the elderly. At best, people in need of long-term health care find only hospitals and nursing homes available.

Because of this lack of alternatives to institutional care, many older Americans must either live in a nursing home, or remain in their homes, where care may be inadequate or nonexistent and where insurance rarely covers their needs.

Consequently, the patient as well as the taxpayer suffers because of unnecessary costly institutionalization. We strongly advocate a shift in the emphasis in Medicare toward more cost-effective care outside of the institution.

Finally, the administration has repeatedly advocated competition in health care. In a market currently controlled by a well-entrenched oligopoly, we can only agree. However, their advocacy of competition has ignored the potential of increased competition among providers.

A majority of health care needs can be provided by a broad range of health care professionals at much lower costs than institutional or physician care. Medicare must begin to focus on the broad range of alternative, cost-effective provider services to meet the needs of the aged population.

A recent GAO report pointed to an increase in premature discharges from institutions of patients in need of further care. If a mechanism is not put into place to attend to these health care needs, patients will undoubtedly return to hospitals, at a far greater expense to the taxpayer. We are dismayed by the failure of the administration to address this crucial need for long-term care reform.

Regarding specific proposals set forth by the administration, we would like to offer the following comments:

Regarding the freeze on DRG payments to hospitals, we are especially concerned about the ability of hospitals to deliver necessary health care services while continuing to cope with incentives to reduce costs.

Further, such a freeze could have significant effects upon the hospital's ability to maintain adequate staffing of health care professionals, which could have a devastating impact on patient care.

The administration's proposal to restructure the way in which it reimburses teaching hospitals for both direct and indirect graduate medical education is of great concern. The ANA feels that it may be premature to make structural changes in GME payments to hospitals, who often provide care to the indigent, until more data on these issues are available.

The home health component of the President's budget proposal calls for what on the surface appears to be a nominal out-of-pocket expense for beneficiaries. However small, this additional expense will place a financial burden on many beneficiaries.

As one alternative to increased costs for beneficiaries, the ANA has endorsed a proposal that would double the current excise taxes on tobacco and alcohol products in an effort to raise funds for the Hospital Insurance Trust Fund.

If this proposal was to be adopted, it is estimated that $18 billion would be generated in increased revenues to the Federal Treasury. In addition, the subsequent reduction in the use of these commodities would clearly benefit the health status of our Nation, and encourage ultimately reducing the financial drain upon Federally-sponsored health care programs through health promotion.

Mr. Chairman, we appreciate this opportunity to express our concerns.

[The prepared statement follows:]

Statement of Barbara Hatcher, R.N., MPH, Immediate Past President, District of Columbia Nurses' Association, and Cabinet of Nursing, American Nurses' Association

Mr. Chairman, members of the subcommittee, I am Barbara Hatcher, RN, MPH, immediate past president of the District of Columbia Nurses' Association, and currently serve on the ANA's Cabinet on Nursing Services.

The American Nurses' Association is a professional association representing 185,000 of the Nation's registered nurses. We appreciate this opportunity to express our views on the problems facing the Medicare Program and the Administration's proposed Medicare budget for fiscal year 1986.

Since the early 1960's the ANA has been on record as a strong advocate of the Medicare Program. The ANA was very active in the development and passage of the original Medicare legislation as well as subsequent legislation implementing a prospective payment system for Part A services, and has been dedicated to preserving the goals that the program is designed to achieve. The Medicare Program represents a remarkable accomplishment in improving access to quality health care for our nation's aged and disabled. Since enactment of the Medicare Program, life expectancy has increased and the overall health of the Medicare covered population has improved. Now, more than ever, the ANA reaffirms its unequivocal support for this program which is crucial to the Nation's health. The American Nurses' Association stands ready to assist policy makers to find solutions to the problems facing the program, ensuring that it can continue its vital role in the Nation's health care.

THE MEDICARE DILEMMA

The dilemma facing the Medicare Program is considerable. There remain severe gaps and inadequacies in the benefits and coverage of the program, and beneficiaries are assuming an over-increasing financial burden for their health care. At the same time, however, overwhelming escalation in medical costs is causing a rapid depletion in the Medicare trust fund.

Inadaquacies in coverage and gaps in benefits are major problems in the Medicare Program. Medicare does not address the long-term needs of the elderly—nursing home and home health benefits are essentially extended care benefits for recuperation from acute illness. People in need of long-term health care find a lack of institutions, services, and personnel trained to provide the help they need without traumatic interruption to their lives. Indeed, those seeking long-term care frequently find only hospitals and skilled nursing facilities available. There are no real options available in a large number of communities in this country. Because of the lack of alternatives to institutional care, many older Americans must either live in skilled nursing homes, where the level of care is often higher than their needs, or try to remain in their homes, where care may be inadequate or nonexistant and where insurance rarely covers their health needs and services. As a result, the patient-consumer, as well as the taxpayer, suffers because of costly unnecessary institutionalization, which also results in the temporary break up of families.

Added to this, increasing copayments and deductibles will continue to pose a growing financial burden to Medicare beneficiaries who are the least able to absorb the increasing costs. While health care cost escalation is a serious problem for all Americans, the problem is compounded for the aged and disabled, many of whom live on fixed incomes. The elderly have approximately half of the income of those under 65 and the proportion of the aged with incomes below the poverty line has been increasing. Although health and health care have improved since the introduction of Medicare, the aged have made little progress in lowering their medical liability. Yet as medical costs escalate, the services and benefits available under Medicare continue to be eroded.

ESTABLISHING A LONG-RANGE FRAMEWORK FOR MEDICARE

It is clear that policy makers must act quickly to resolve both the benefits and financing dilemma facing the Medicare Program. Although neither the issues nor options are simple, we feel that there are essential principles to which the solutions must adhere. Within these principles, there are proposed solutions which are clearly inappropriate as long-range remedies, but there are also directions which policy can take which will maintain the integrity of the Medicare Program.

The Medicare Program must be preserved as a system which provides the elderly and disabled with appropriate, high quality and cost effective protection against the expenses associated with poor health, rather than a system which increases the burden of these vulnerable populations. The health of our aged and disabled citizens is vital to the overall well-being of our Nation. We cannot afford, nor is it desirable, to erode the quality of health care we provide to these elderly and disabled people. In fact, it is crucial that solutions concentrate on exploring options to expand and improve the benefits and coverage of the Medicare Program.

Any changes made in the Medicare Program must be within the context of the entire national health delivery system. Such a system must include such activities as health planning and peer review of professional practice decisions, such as PRO's, if cost containment is to become a reality. Thus, changes which merely shift costs from the Medicare Program to other sources, will not affect the overwhelming problem of escalating national health expenditures. Furthermore, solutions must take into account all of the major sources of cost escalation.

Many of the proposed solutions have concentrated on slowing the drain in the Medicare trust fund by increasing the financial liabilities of the beneficiaries. Not only will the solutions add an insurmountable burden to the already vulnerable disabled and elderly populations, they will continue to erode these populations' access to quality care services.

Increases in Medicare copayments and deductible, or reductions in benefits, for example, may improve the financial outlook of the HI trust fund, but it is unlikely that this option would significantly affect overall medical care costs, but merely shift them to other sources as well as adding enormous burdens to the vulnerable Medicare populations.

Rather than resulting in any long-term slowing of health care cost escalation, these options will result in shifting costs of care to other sources, including the already financially burdened Medicaid Program, the public hospitals and other public programs, which are clearly not in a financial position to absorb all of these responsibilities.

Moreover, a reduction in benefits will add considerable pressure to the already troubled public hospitals. A reduction in benefits will not mean a reduction in the need for these benefits, which means care will be provided through other sources—primarily, the public institutions.

Medicare voucher proposals would have similarly undesirable effects, and would cost the Federal Government and the elderly many billions of dollars more each year. While a voucher concept may be appropriate for the younger population, it is inappropriate for an older population who in general are in poorer health and because of their health state are not in the best position to make decisions about what insurance to buy.

In our view, the use of vouchers will be plagued by the lack of consumer information and confusion regarding health care, which can only be exacerbated for the elderly, who would become even more burdened by the difficult and complex choices required by the competitive proposals. The elderly are one of our more vulnerable populations, least able to afford increases in out-of-pocket expenditures for health care. Therefore, we believe that the use of vouchers would not be in the best interest of our aged and disabled citizens.

It becomes clear from examining some of the strategies that have been proposed that solutions to the Medicare dilemma which improve the elderly's access to quality care, improve the financial soundness of the program and help reduce overall health care cost escalation, requires a shift in focus. The current health care delivery system is now provider—i.e.hospital and physician—dominated, so that enormous financial benefits accure to these providers at the expense of the elderly population and the public. Medicare should not be used primarily as a financial benefit for providers, but as a benefit for the elderly and disabled populations that improves access to health care.

SOLVING THE MEDICARE DILEMMA

If Medicare is to improve its benefits to the elderly while reducing their financial burden, improve the financial outlook of the Medicare Program, and encourage a reduction in overall health care costs growth, it must shift its emphasis from encouraging the use of institutionalization and related health care services, to a broadening of alternative, lower cost health care delivery which is sufficient to cover the range of health care needs. There are certain strategies that must be pursued in order to accomplish the goals of the Medicare Program, within the principles we have outlined.

It is, therefore, essential that the prospective payment system mechanism, fixing the level of payment before services are provided, be retained to provide maximum financial incentives to providers to contain costs and slow the drain on the Medicare Program. Congress should, however, address the questions of adjustments to DRG weighing factors regarding the level of intensity for nursing services and geographic variations affecting hospital costs.

Another strategy that must be implemented is to shift the emphasis of the Medicare Program from the most costly institutional health care services to a broader focus on more cost-effective alternative providers of health care outside of an institution. A redirection in Medicare coverage to allow for prospectively paid primary health care services at home and in noninstitutional community setting would provide cost-effective alternatives to institutionalization. The vast majority of the health care needs required by the aged and disabled are not those which require costly medical treatment or hospital stays. Health care for these populations requires, in large part, a full range of services from health maintenance and disease prevention, to care during acute illness to chronic disability.

The majority of these health care needs can be provided by a broad range of health care professionals—at much lower cost than institutional or physician care. It is important that Medicare encompass and focus on the broad range of alternative, cost efficient provider services to meet the needs of the aged and disabled populations. The continued physician control of the patient's access to other health care providers merely serves to exacerbate health care inflation. In the interest of both economics and the quality of health care, nonphysician providers must be given a greater role in providing services to meet the Nation's health care needs.

Finally, to improve the Medicare population's access to health care while ensuring cost-efficiency, it is essential that all levels of government provide the necessary commitment and support. Primarily, the Government must maintain and strengthen health planning. The Federal Government which pays an enormous proportion of the cost of health care has such a crucial and obvious interest in ensuring that the system operates efficiently. Past experience indicates that deregulation leads to proliferation of costs. It is vital that the Federal Government ensure that the limited financial resources devoted to health care are used in the most efficient manner.

THE ADMINISTRATION'S MEDICARE PROPOSALS—HOSPITAL PAYMENTS

The Administration proposes to freeze DRG payments to hospitals at 1985 levels for 1 year. This proposal, if adopted, would cut program costs by $1.8 billion in fiscal year 1986. While supportive of initiatives to control health care costs, ANA raises the following concerns about a proposed freeze on DRG rates:

The capacity for hospitals to deliver necessary health care services of high quality while continuing to cope with incentives to significantly reduce costs.

The ability of hospitals to continue to provide access to health care services to populations such as the poor and the elderly.

The variability of patient acuity levels within each DRG, especially in relation to nursing care requirements.

The impact on hospital labor and changes in marketbasket calculations based upon geographic regions.

An unexpected change in hospital reimbursement policy in the recently enacted prospective payment system [PPS] may not allow sufficient time for hospitals and health care professionals to have assessed the impact of the initial PPS system on their services.

FREEZE ON DIRECT AND REDUCTION OF INDIRECT MEDICAL EDUCATION PAYMENTS TO TEACHING HOSPITALS

The budget submitted to Congress by the Administration calls for freezing payments for direct medical education for a proposed saving of $150 million in fiscal year 1986.

The Administration further proposes to save $695 million by reducing by 50 percent, supplemental payments to teaching hospitals for the indirect costs of their training programs. If enacted, the ANA urges Congress to consider the following:

Medicare funding for nursing education does not accurately reflect the changing trends in nursing education since the enactment of Medicare 20 years ago. The majority of the Nation's nursing programs are now located in institutions of higher education, as opposed to 20 years ago when they were mostly hospital-based diploma programs. Medicare still mandates, however, that reimbursement can only be made for nursing education occurring in hospital settings. As a result, a hospital-based nursing education program can be reimbursed under Medicare for most of its costs because they are contained in the hospital's cost report; on the contrary, a nursing education program based outside of a hospital, e.g. a university program, can only be reimbursed for its clinical component costs because they are hospital-related.

While it is clear that there is currently a pass-through under PPS for direct medical education costs, the definition of "allowable direct nursing education costs" is unclear.

Indirect medical education costs are a subsidy payment for the acknowledged higher costs associated with a teaching hospital, such as costs of the education of non-physician providers like nurses, as well as the costs of treating more severely ill patients. The indirect adjustment is based solely on a ratio of the number of interns and residents to hospital beds. However, Medicare does not acknowledge the unique indirect costs for nursing education in a hospital unless the hospital is also affiliated with a medical school. A hospital that does not provide residency programs for physicians has no way of recovering the indirect costs of the clinical nursing education programs.

Changes in GME payments may result in the movement of teaching hospitals to significantly reduce costs by cutting nursing staff.

Alternatively, changes in DME and IME payments may unfortunately result in teaching hospitals billing for the use of their clinical facilities. The hospital could bill either the nursing program of an institution of higher education, the nursing student, or both. All of these possibilities would create a huge financial burden and would also be a deterrent in terms of student recruitment and enrollment.

It would be premature to make structural changes in the payment mechanisms for GME, especially as it pertains to nursing education, until more data on these issues are available. Several professional organizations, hospitals, as well as Federal and State legislators are studying the problem. More time is needed to analyze the potential impact of a variety of proposals.

Home health

The President's budget proposal would implement a copayment of one percent of the hospital deductable for each home health visit after the 20th such visit in a calendar year. While on the surface, this may appear to be an initially nominal out-of-pocket expense for beneficiaries, it will create a major financial burden for some Medicare patients and may even preclude other Medicare patients from obtaining access to necessary health care services. Recent experience with Prospective Payment indicates that many patients are discharged prematurely, in need for further nursing services. The Administration's proposals would reduce this availability at the time they have increased the neccessity for home care.

Skilled nursing facilities

Administration budget proposals call for the freezing of SNF's payment rate at the 1985 level. The ANA is concerned about the proposal in light of new evidence that some hospitals are discharging patients prior to a full recovery, and in poor health, which in turn places greater pressure on SNF's to handle this increase in nursing care needs in their patient population. In order to maintain a high level of quality care for its patients, SNF's must be funded adaquately. These high standards may be impossible to meet as the patient population increases and funding decreases.

Beneficiary proposals

The Administration has made several proposals regarding changes in beneficiaries eligibility and financial liability for Medicare services:

Delaying initial Medicare eligibility from the first day of the month a person reached age 65 to the first day of the next month.

Indexing the $75 Part B deductable to the medical care component of the consumer price index beginning in fiscal year 1987.

Extending secondary payer coverage.

Establishing a voluntary voucher program which would allow beneficiaries to enroll in private health plans instead of Medicare.

Raising the Part B premium for 25 percent of program costs to 35 percent by 1990.

The ANA has long been on record as opposing increases to the out-of-pocket costs of beneficiaries. The majority of people who are covered by Medicare are those that are least able to afford such increases. Furthermore, the ANA sees several of these proposals as merely shifting the responsibility of health care delivery onto the shoulders of private health care providers, rather than establishing a long term policy agenda to rectify current problems.

As an alternative to raising beneficiaries expenses, the American Nurses' Association endorses legislative proposals that would double federal excise tax on all tobacco and alcohol products in an effort to raise revenue for the Medicare Hospital Insurance [HI] Trust Fund. ANA urges Congress to adopt this approach to maintaining the financial solvency of our Nation's health care system as an alternative to reducing recipient's benefits or increasing an individuals out-of-pocket expenses for participating in these programs.

The health care costs to the Federal Government incurred by tobacco and alcohol consumption should be financed, at least in part, by those individuals who choose to use these products. ANA feels that it is a fair and equitable method of taxation. Those who utilize federal health care benefits more than others should be required to pay more for the services received.

An increase in the current tobacco excise tax to 32 cents per package would generate approximately $8.5 billion in fiscal year 1987. A similar doubling of the current excise tax on all alcoholic beverages would yield approximately $9.4 billion in fiscal year 1987. This approximately $18 billion, if allocated to the HI Trust Fund, could virtually negate the medical costs associated with the use of tobacco and alcohol products.

Aside from the monetary benefits additional taxes could create, the subsequent reduction in the use of these commodities would clearly benefit the health status of the Nation. ANA feels that the economic discouragement of the use of tobacco and alcohol products could be a significant step toward encouragement of health promotion policies that would ultimately reduce the financial drain upon federally sponsored health care programs.

Chairman STARK. Thank you very much.

It is interesting, in comparison with the last panel, and I guess we would have to ask this of both witnesses, but if I read your testimony, Dr. Rogers, you would in effect support all the beneficiary cuts, but none for the providers, so to put you in exact juxtaposition with the American retired people.

Let's assume, in balancing the budget, we must get the providers to go along with a cut. I for one do not intend to support postponing the increase for those who accepted assignment in return for a promise that they were going to get an increase.

That is something that I think the Congress committed, and to me, that was a contract, and I would like to set that aside for a minute. I wanted the AMA to know that while I may never have agreed with them on anything except the nuclear freeze, I do think for those physicians who in a social sense accepted voluntary assignment in exchange for a raise in their fees, that it is a promise to be fulfilled.

One option we have is to freeze payments for nonparticipating physicians and fulfill our obligation to allow an increase for participating physicians. We could go to making a union out of the AMA, and dealing with you on DRG-type payments for physicians' fees, or go to a Canadian-type program with various fixed fees.

If we have to move in to your area on the provider cuts, which are you most willing to negotiate with? If we can't take it all out of beneficiary side as you would propose, can we take some out of the provider side?

Dr. ROGERS. Mr. Chairman, we feel the physicians have already been cut, in essence, by being frozen.

Chairman STARK. So, do the senior citizens feel they were cut last year?

Dr. ROGERS. I want to get that on the record first.

Chairman STARK. I understand very clearly your feeling is you have suffered a cut because of increased costs of inflation and I will emphasize that for you in the record.

Recognizing that, where, if we had to begin with just the AMA, should we begin?

Dr. ROGERS. HHS has asked the AMA and other organizations to look at the issue of physician reimbursement and we are in the process of doing this today, and in the process of evaluating a relative value study for physicians as an alternative to the DRG system for paying physicians.

We have looked at the DRG issue and feel it probably would be inefficient and would not result in an overall saving of money for the Federal Government. We do think the relative value study might well have some promise in this area. We are too new into this area to be able to give you an exact answer at this time.

That is where we are going to put our money.

Chairman STARK. Thank you.

Let me ask, Ms. Hatcher, although you have come down squarely on both sides of the issue, you don't want to see the beneficiaries or the patients incur any more costs, the senior citizens, and those nursing groups who are not represented by a bargaining contract.

Where, if we had to ask your profession to begin negotiating with us, would you prefer to begin?

Ms. HATCHER. If we saw a strong commitment to across-the-board cuts, we could also look at proposals for health care also.

Chairman STARK. That is a great answer.

Ms. HATCHER. We would have to see a strong support and be sure that indigent care was not suffering.

Chairman STARK. I am sure this committee recognizes the need, and we have all read the articles, for long-term care. I am new to this area, but as near as I can determine, it was never intended to become a part or be a part of medicare; that is, long-term or nursing care, not skilled nursing facilities. That does not mean that the committee is not interested and it is not a concern.

It just means that it is not really under discussion at this point when we are talking about cutting fees, money elsewhere, and I don't want you to think we are ignoring it. We are very aware of it.

Mr. Gregg.

Mr. **Gregg**. Thank you, Mr. Chairman. As I understand both witnesses, you are willing to consider a freeze as long as it is in the context of an across-the-board freeze, all areas of Federal spending?

Dr. **Rogers**. Yes, sir.

Mr. **Gregg**. Dr. Rogers, can you tell me what your timeframe is for coming up with this additional proposal that HHS has asked you for?

Dr. **Rogers**. They have withdrawn their suggestion that we do it. We are going to the FTC to see if they will allow us to do it as an organization individually. Nine months to a year would be the minimum timeframe for completing this study.

Mr. **Gregg**. What do you expect the substance to be?

Dr. **Rogers**. A reevaluation of how physicians are paid. Relative value studies in the past, notable the California study, have been based on charges by physicians. This new study would be based on resources used in the service provided and would include education, time, complexity of the situation, the malpractice problems associated with it, and every facet of the resources used in the physicians' participation in the care of a patient.

If we can arrive at a reasonable allocation of this sort, we can then, in effect, let it be used by third parties, by the Federal Government, and anybody else. This would set reimbursement decisions on a much more rational basis, and it would result in some savings of money to the Federal Government.

Mr. **Gregg**. Do you envision this study coming back and telling us that surgeons are receiving a disproportionate compensation in relationship to an internist?

Dr. **Rogers**. I am a surgeon. I think you will find that there will be an equitable distribution of relative value of services between the specialties, yes, sir.

Mr. **Gregg**. We have a surplus of physicians in the country right now, as I understand it, and it is projected that we are going to continue to have a surplus right through the year 2000.

In light of that, it would appear that competition should bring down prices if the marketplace were open. Yet, we still see the price of physicians' fees and physicians' services rising at two to three times the rate of inflation.

What is your analysis as to why competition with this surplus is not bringing the price down?

Dr. **Rogers**. Your information is correct, we see the same thing. This is probably based on the fact that there is a greater demand for health care than we have appreciated in the past. As you increase the numbers of people who are available to provide health care services, you immediately fill the void that has been there and you use more health services.

It is the rate at which we use the health services that makes the difference. As we increase the number of doctors, we are going to see the health care bill increase, because services will be used at a greater rate.

Mr. **Gregg**. You are saying we are going to have to come up with a system that will control the use of services so that they won't be abusively used and overused?

Dr. **Rogers**. That is what has been done already with the development of the PRO Program.

An essential role of the PRO Program is to look at services to be sure that the services are needed. The other side to that, and we are concerned about this, is to assure that needed services are not denied. It will rest squarely on the shoulders of the practicing physician across the country to be certain that his patient does not adversely have his health care affected.

Mr. **Gregg**. Of course, the PRO Program is a quasi-regulatory approach toward that issue. Is there a marketplace approach that can be taken to effect utilization?

Dr. **Rogers**. I think we are seeing the marketplace approach going on today. The so-called alternative delivery systems are mushrooming around the country. We are seeing doctors and other health care providers participate in HMO's, and PPO's, to the benefit of patients, because they are providing services at a lesser rate for these patients.

Mr. **Gregg**. Is it your assessment that the cost of HMO's is less because they have a healthier patient as a client, or because they are actually delivering services in a more cost-effective manner?

Dr. **Rogers**. Both are true. They do attract a healthier clientele. They like to enroll those people who live on the fourth floor without an elevator, but they also provide fewer services. They provide more out of hospital services, and the hospital, of course, is the most expensive place we can deliver care.

Care delivered at home or at my office is far cheaper. They do provide more care at that level.

Mr. **Gregg**. Thank you.

Chairman **Stark**. Mr. Pickle.

Mr. **Pickle**. Dr. Rogers, last year the AMA endorsed a voluntary freeze on physicians' fees. You said 80 percent of the physicians were volunteer. How did you arrive at that?

Dr. **Rogers**. We asked them. We sent surveys. It was done by telephone and the telephone respondents, nearly 80 or 79 percent, did say they had frozen their fees. Because of this, we feel that the increase in physician fees was abated during that year.

Mr. **Pickle**. Now, if we were to freeze the physician fees and you would all participate—what impact do you think that might have on the overall utilization practices by physicians, any impact?

Dr. **Rogers**. I think that it probably would not in and of itself have an effect on it.

Mr. **Pickle**. Well, we hear that the physicians simply conduct additional tests, order a new kind of test, or reevaluation. Is there substance to this rumor?

Dr. **Rogers**. I have heard the same statements. I know of no documentation to substantiate that. However, under the DRG system, patients are being discharged quicker and sicker, and they require rehabilitation services or home health care services that they did not require before. There are additional services that are being required.

Mr. **Pickle**. State by State, the number of participating physicians varies. Pennsylvania has about a 50-percent participation rate; Oklahoma, 10 percent; and Texas, about 20. Why is there that great a variance among States?

Dr. ROGERS. You have different people in those States. They either agree or disagree with the program based on a lot of other things. We have been impressed with the overall number of doctors who take an assignment, however.

With the increase in the numbers in the last few years, there has been a dramatic change in the numbers of assignments that the doctors are taking.

Mr. PICKLE. Many private health plans are increasingly requiring second opinions for certain high-cost elective operations or surgical procedures.

Now, would the AMA oppose this second-opinion provision if it was recommended?

Dr. ROGERS. No, I don't think we would oppose it. We have to have it demonstrated it is going to save money and not damage our patients. So often, in a case of this sort, you simply delay a needed procedure and that can save money, but it may make it inconvenient or uncomfortable for the patient.[1]

Mr. PICKLE. It is being required by private industry more and more. If it is part of the medicare bill, would the AMA accept that?

Dr. ROGERS. Yes, I think we would. I will have to tell you that last week, I was getting ready to operate on a man with a gangrenous gall bladder and we had to call back to the Medicare office and get a Medicare approval on this man.

He was sick as a goat.

Mr. PICKLE. Let me ask Ms. Hatcher one question. I have heard it said that nurses are being laid off now in various hospitals because of the DRG's. Is this a fact?

Ms. HATCHER. Yes, in some areas of the country, this has occurred. As a result of the DRG payments, those hospitals that have not been able to make money have had to look at laying off personnel and nursing personnel is often a large part of a hospital's budget.

Mr. PICKLE. Where do they go if they are laid off?

Ms. HATCHER. Some of the nurses go into community health. Some nurses do other kinds of jobs for which they may be retrained.

Mr. PICKLE. Home health services?

Ms. HATCHER. Yes, because there is an increase in home health and long-term care needs.

Mr. PICKLE. Thank you, Mr. Chairman.

Chairman STARK. Thank you.

I want to thank the panel. Again, I am sure that we will have occasion to call on you and your organizations as we try and do what is best. Thank you very much for your testimony.

[The following letter was subsequently received:]

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[1] See supplemental information received, infra.

American Medical Association,
Chicago, IL, April 16, 1985.

Re: Surgical Second Opinions.

Hon. J.J. Pickle,
House of Representatives, Cannon House Office Building,
Washington, DC.

Dear Representative Pickle: This letter is to clarify our response to you concerning your question on surgical second opinions. Recognizing that the advisability of surgery or other specific therapy can be a matter of opinion, the American Medical Association: (1) reaffirms the right of the patient or a physician to seek a second opinion freely from any physician of choice; (2) opposes the concept of mandatory second opinions or the imposition of financial penalties by a third party payor for not obtaining a second opinion; and (3) supports the concept that when a second opinion is required by a third party that second opinion should be at no cost to the patient.

The AMA firmly believes that voluntary second opinions are valuable for both the physician and the patient. Where either party voluntarily solicits a second opinion, the second opinion can help in establishing a direction for the course of treatment. Also, such an opinion may have the effect of saving money if it presents an alternative course of treatment which proves to be less expensive than the surgery initially considered. Finally, a second opinion can encourage a patient to have needed surgery when the patient might have reservations concerning the surgery or initially chooses against the surgery recommended by the first physician.

The only way to truly know whether second opinions against surgery save money and reduce health risk is to compare over a long period of time the potential cost and value of a surgical procedure against the cost and quality of care provided in place of surgery, the long-range medical implications, and the quality of life for the patient who initially did not have the surgery. In addition, there are serious questions as to the cost-effectiveness of a mandatory approach, in that savings resulting from deferred surgery may be more than offset by the costs of obtaining the second opinions and the alternatives to and consequences of deferral.

The AMA is opposed to mandated second opinions before every elective surgical procedure. While second opinions are in many cases valuable, we are concerned that their mandatory imposition into the existing patient/physician relationship could have a deleterious effect on that relationship and it could impose an element of doubt in a patient's mind at a time when that patient is most in need of a strong belief in the views and abilities of his or her physician. Patients should be presented the option of seeking a second opinion for treatment decisions, instead of being automatically subjected to mandatory second opinions. We believe patients will be better served if the federal government encourages second opinions instead of requiring mandatory second opinions.

Sincerely,

James H. Sammons, M.D.,
Executive Vice President.

Chairman **Stark**. Our next panel is composed of Mr. Jack Owen, American Hospital Association; Mr. James Mongan, excutive director, Truman Medical Center, representing the Council of Teaching Hospitals and the Association of American Medical Colleges; and Mr. William Pinkston, executive director, Grady Memorial Hospital, National Association of Public Hospitals.

Please proceed to expand on your prepared statements or summarize. Mr. Owen?

STATEMENT OF JACK W. OWEN, EXECUTIVE VICE PRESIDENT, AMERICAN HOSPITAL ASSOCIATION

Mr. **Owen**. I really appreciate this opportunity to testify today. Let me start off by saying, as you heard before, hospitals have lived up to the commitment on the PPS Program.

It is obvious that, because this past year we only had a 4.5-percent increase in the cost of hospitalization, the rising costs of hospital care are not what they were a few years ago.

We have concerns about the President's proposed budget, because of the cuts that have already been established for the Medicare Program, some $24 billion that Congress has enacted, which will be effective over the next 3 years.

We also were part of a coalition of some 39 members that raised concern about proposed fiscal year 1986 cuts in Medicare. Recognizing the problem that you and your committee have, we would like to say that we do have a willingness to contribute to a fair effort to reduce the deficit, and I am here today to tell you that if it is a fair, across-the-board cut, that we are willing to do our share.

Specifically, I would like to raise a couple of issues that are in my testimony. If this freeze is to be effective, we would like very much to see that it be legislative rather than administrative.

We feel it is important that it be done by Congress and not by administrative action. If the freeze is to be effective, we want to be sure that the inequities due to the operation of the DRG Program are not allowed to continue during the period of the freeze. Hospitals will face recalibration of DRG rates, even rate reductions, if some kind of a hold-harmless clause to guarantee hospitals they would be paid the rate as of September 30, 1985, is not approved—so we don't have a freeze and find out the administration has reduced the rates.

We have a concern about medical education payment reductions because they go beyond the freeze. These are actual cuts, and what effect that might have on training of personnel in the future.

We are very concerned about the cuts on the indirect medical education of cutting that formula in half. It must be remembered that the formula was developed on the basis that it would serve as a proxy for intensity and for severity of illness, and also to help take care of the disproportionate share of hospitals, those hospitals that have a large number of patients who do not pay the uncompensated care load. By halving this, you are going to create some problems for these inner city hospitals and large teaching hospitals.

Last, we are concerned that beneficiaries in the long run will also have some problems, because as you cut back and as we have to live with 4 percent this year, and a freeze for next year, that makes over 2 years with only a 4-percent increase, with inflation and cost of living going up somewhere around 5 percent. We are talking about a 10-percent increase over those 2 years, that there may be a loss of accessibility for the elderly patient.

If the freeze is extended, and if direct cuts in medical education and indirect medical education go through, it means that there will be a larger portion of uncompensated care and hospitals will have to look to eliminating some of the services that they now render.

That does not mean that they are going to close down, but they may eliminate some of the services, and that means access for many elderly citizens. We are willing to work with the committee and will do so in any way you see fit.

Chairman STARK. Thank you, Mr. Owen.

[The prepared statement follows:]

STATEMENT OF JACK W. OWEN, EXECUTIVE VICE PRESIDENT, AMERICAN HOSPITAL ASSOCIATION

SUMMARY

The American Hospital Association [AHA] recognizes the importance of reducing the federal budget deficit. The AHA's member hospitals are willing to do their share; in fact, hospitals already are contributing through their acceptance of and responsiveness to the Medicare prospective pricing system. In the AHA's view, further reductions, unless done evenhandedly, would impose a disproportionate burden on Medicare beneficiaries. Such cuts include, but are not limited to, a "freeze" on Medicare hospital payments and reductions in medical education reimbursement. While a "freeze" appears to treat all hospitals equally, as proposed by HHS it actually would result in significant reductions in payments to certain hospitals, particularly those that serve as referral centers and those that treat the most complex cases. In addition, for hospitals not able to absorb budget cuts, the proposals would exacerbate existing and anticipated problems arising from certain inadequacies of the prospective pricing system, including flaws in diagnosis-related groups (DRGs). Because hospitals are responding strongly and positively to incentives of the system, further efforts should build on, rather than detract from, this success.

INTRODUCTION

Mr. Chairman, I am Jack W. Owen, executive vice president of the AHA. The Association represents over 6,100 member hospitals and health care institutions that annually provide services to more than 10 million Medicare beneficiaries. The Association also includes approximately 38,000 personal members. I am pleased to have this opportunity to present the AHA's views on certain HHS fiscal year 1986 Medicare budget proposals that are of concern to the hospital field.

In my statement, I address the following HHS Medicare budget proposals: to "freeze" payments to hospitals, to reduce medical education payments, and to increase beneficiary costs. In addition, I discuss the implications of these proposals for hospitals and beneficiaries, as well as relevant trends in hospital performance.

ADMINISTRATION PROPOSALS

HHS' fiscal year 1986 budget proposals affect various aspects of the Medicare program, from services provided by hospitals, physicians, and other providers, to benefits for beneficiaries. These proposals, in the AHA's view, would have adverse effects on health care in this country. In fact, the AHA has joined with 39 other groups, ranging from the American Association of Retired Persons to the Health Industry Manufacturers Association, to the National Association of Counties, to the Service Employees International Union, in submitting a letter to Congress seeking rejection of the proposals.

Primarily, the AHA is concerned that the overall budget aproach would require a disproportionate sacrifice by the nation's elderly. While many of the proposals at surface level seem to apply only to providers, changes in provider payment ultimately would affect the type and acceptability of services available to Medicare beneficiaries. Other proposals, focusing more explicitly on beneficiaries, could create substantial barriers to access for some segments of the Medicare population. Taken together, the budget proposals make substantial changes in the structure of the Medicare program. While the AHA believes that some restructuring is necessary, it contends that alterations be made only after full and adequate deliberation, with attention to the longer-term consequences of the new policies.

Some of the budget proposals are characterized as "freezes" on Medicare payments. In fact, one of the proposals would actually reduce real Medicare expenditures. Of the hospital proposals, a 50-percent reduction in the so-called "indirect medical education" factor would result in a loss of nearly $700 million. To save this sum, hospitals receiving education-based payments would have to spend reserves, cut services, and eliminate more than 25,000 staff, or shift these costs to the private sector. Because the institutions receiving these payments are important sources of referral care in their states and communities, the availability of their referral services to many beneficiaries could be jeopardized seriously by artificially imposed reductions in payment.

Freeze on prospective payment system payments

The major HHS Medicare budget proposal is a "freeze" on hospital payments under the DRG-based prospective pricing system. This action would reduce Medicare expenditures by approximately $1.8 billion in fiscal year 1986. A second, but parallel, budget proposal is a "freeze" on payments to "exempt providers," i.e., psychiatric hospitals and units, rehabilitation hsopitals and units, children's hospitals, and long-term-care hospitals.

A 1-year "freeze" in payments would not be an insurmountable problem for some hospitals. Because of the transition toward uniform rates, some hospitals will receive more than a "marketbasket plus one percent" increase in prices in the absence of a "freeze." For these hospitals, a "freeze" would simply mean a smaller increase. However, the outlook is different for other hospitals: a "freeze" would increase the size of the cuts they already will have to make in their operations to avoid substantial losses under the current transition.

The Administration, as stated in HHS fiscal year 1986 budget documents, is proposing to implement administratively—without congressional action—many aspects of its "freeze." Moreover, the Administrator of the Health Care Financing Administration has indicated in recent statements that a further downward revision of the prices is contemplated to correct for an alleged additional increase in Medicare case mix due to coding improvements that have occurred since the implementation of prospective pricing. Rather than a "freeze," such a change would constitute an outright reduction in payments.

In numerical terms, it is difficult for two reasons to project the impact of the HHS proposals. First, most hospitals are less than halfway through their second prospective pricing year, while others have not even completed their first year. As a result, the impact of changes already made cannot yet be determined. Moreover, results from fiscal year 1984 will become increasingly irrelevant in assessing the current impact of prospective pricing. Second, the range of possible hospital responses is extremely large. Variation in responses will tend to make the detection of dramatic changes difficult because such responses will differ among groups of hospitals, and may have to be spread out through time.

The AHA's approach in assessing the impact of prospective pricing is to identify the overall magnitude of changes that will be required for hospitals to maintain their financial positions, and in particular to look at groups of institutions in which an unusually high proportion of hospitals would have to make either changes in their operations or large adjustments.

The hospitals that would be most disproportionately affected by the proposed "freeze" include large hospitals in both urban and rural areas, teaching hospitals, and hospitals with the most complex case mixes. The impact on the last group of hospitals is particularly troublesome. Although the DRG system is supposed to capture and adjust for differences in hospital case mix, the anticipated impact of a "freeze" on hospitals treating relatively more of the "higher cost" patients is further evidence that the DRG system does not completely adjust for case-mix differences.

Medical education payment reductions

As noted above, the fiscal year 1986 budget proposals include reductions in so-called medical education payments, including a "freeze" on payments to cover the direct costs of medical education and a 50-percent reduction in the "indirect medical education factor." The cuts in Medicare expenditures that would result from these proposals are $150 million and $690 million, respectively. It is difficult to assess the impact of the direct medical education payment "freeze" proposal, because the budget documents give no indication of how it would be implemented. Although many options are possible, there has been no opportunity to discuss these alternatives with the Administration.

The simplest, and least disruptive, approach would be simply to "freeze" the direct medical education payment at the level made in the hospital's fiscal year ending in fiscal year 1985. Because the effect of the cutback would be limited to teaching hospitals, it would fall on those hospitals providing much of the referral care needed by Medicare beneficiaries.

The reduction in the so-called indirect medical education factor would greatly exacerbate the problems anticipated by hospitals treating complex Medicare case mixes. The original doubling of the indirect medical education factor was intended by Congress to correct for the inability of DRGs to distinguish adequately among the case mixes of different hospitals. Albeit crude, the doubling was a method of addressing the problem. It may have led to slight "overpayments" for some hospitals, and the opposite for others, because the prices paid to all hospitals were reduced to keep total payments "budget neutral." Cutting the factor in half, and removing the funds from the Medicare budget, penalizes all hospitals, without solving the original problem.

An alternative to the indirect medical education factor is urgently needed, preferably a method for more adequately adjusting for case-mix differences among hospitals. Moreover, some form of "disproportionate share" adjustment is needed for hospitals treating a disproportionately large number of low-income patients; our analyses and those of some other organizations indicate that such institutions, whether teaching or non-teaching, have higher Medicare costs per case.

Beneficiary provisions

The Administration's budget includes several provisions that directly affect beneficiaries. One would gradually increase the Medicare Part B premium from its currnt level of approximately 25 percent of Part B expenses to approximately 35 percent of such expenses, for savings of $332 million. A second proposal would establish a copayment for home health services, for savings of $65 million. While these proposals would have a limited impact on many Medicare beneficiaries, they could work substantial hardship on low-income Medicare recipients. For some, the required premium could force them to drop Part B coverage, which could lead to increases in state Medicaid expenditures or uncompensated care costs, or both. The most serious effect could be the creation of substantial barriers to access so that beneficiaries would not seek needed services.

Any effort to alter the cost-sharing provisions of Medicare should be based on a careful consideration of the effects of such proposals on various groups of the Medicare population. Cost-sharing can be a powerful tool for increasing cost consciousness and shaping utilization, but it must be applied judiciously. Relatively little is known about the relationship between age, income, and the need for medical services. Until these complex relationships are sorted out, it is best to proceed cautiously.

IMPLICATIONS OF THE ADMINISTRATION'S PROPOSALS

The AHA originally proposed Medicare prospective pricing as the most effective means of moderating the rate of growth in Medicare program outlays for inpatient acute services. The Reagan Administration and Congress agreed with that position, and adopted prospective pricing as the basis of payment for inpatient hospital services by Medicare. The AHA, working with Congress and the Administration to anticipate problems and fix them before they become significant, has supported the implementation of prospective pricing. More importantly, hospitals have supported its adoption and responded forcefully and positively to its incentives, as well as to the incentives of new, competitively oriented financing systems in the private sector. As a result, in 1984 hospital expenses rose 4.5 percent, the lowest rate in 22 years, and Medicare expenditures increased at the lowest rate since the inception of the program. Equity problems remain, but are solvable.

The idea underlying the prospective pricing system is that payment based upon prospectively determined prices creates incentives to keep costs below the price and provides greater predictability for both hospitals and the Medicare program. Under a prospective pricing sytem, the hospital is at risk for the difference between costs and prices, as well as for fluctuations in volume. Because volume can change rapidly and unexpectedly, operating under a prospective pricing system is risky, but the risks are generally manageable. Because volume is unpredictable, predictable prices are important. Predictability of prices is particularly significant because Medicare prices are not set by the hospital. Hospitals can plan and budget rationally, matching the services they offer to the needs of their communities, only if they can count on the revenue needed to support their services. While the exact schedule for prices that will hold over a period of years cannot be known, hospitals do need to know what the general level or trend in prices will be. Congress attempted to provide some certainly in the prospective pricing legislation by establishing a general formula: prices were to increase by a formula of "market basket plus 1 percent" during the first two years of the new system. In subsequent years, "market basket plus one percent" was to be a general baseline for the HHS Secretary to use in setting the prices.

Prices have not, however, been predictable. Within 6 months of the implementation of prospective pricing, Congress changed the pricing formula from "marketbasket plus 1 percent" to "marketbasket plus one-quarter of 1 percent." The Secretary, in setting prices for fiscal year 1985, proposed to reduce prices by 3.4 percent, allegedly to "correct" for inaccuracies in the data initially used by HHS to set prices. Eventually, HHS reduced prices by 1.05 percent. For the third prospective pricing year, further changes are being contemplated by both the Administration and Congress. While some of the uncertainy that these changes are creating is appropriate, because a complex system inevitably will have a "shakedown period," much of it is not, because it is resulting from changes in policies intended to produce additional "savings" rather than to correct problems with the system.

Hospitals recognize the need to reduce the federal budget deficit, and are willing to contribute their fair share to the deficit reduction effort. In determining this "share," in terms of efforts to cut Medicare spending, the potential adverse effects on the ability of individual hospitals—and the hospital system as a whole—to provide Medicare beneficiaries with the services they need must be minimized.

By necessity, the hospital industry is making major changes to adapt to the prospective pricing system. The full consequences of implementing that system are still largely unknown. A "freeze" on Medicare payments would require an even larger and faster response, particularly from those hospitals which must make the most substantial changes to adapt to the new payment system.

HOSPITAL PERFORMANCE

The Medicare prospective pricing system is not the only change in the hospital payment system. Private sector efforts have been equally significant. Various forms of prospective pricing, including preferred provider arrangements, are reshaping the traditional hospital-payer relationship. The hospital response to these developments has been swift, dramatic, and varied. While separate data on Medicare and non-Medicare patients are not available, the figures that are obtainable strongly suggest that both Medicare and non-Medicare patients are benefitting from lower costs. The financial position of hospitals is also slightly improved, despite the uncertainties and pressures of the new environment, reflecting in part the initial lowering of costs and in part the "cushion" needed to protect against unforeseen events. Because hospitals are "at risk" for differences between prices and costs, the need for such a cushion is substantially greater under prospective pricing than under cost-based systems.

During calendar year 1984, total hospital expenses rose 4.5 percent, less than one-third of the rate of increase 2 years ago (15.8 percent) and less than one-half of the 1983 rate (10.2 percent). In patient expenses in 1984 increased only 3.2 percent. The dramatic slowing of the rate of increase in costs is largely the result of three factors. First, admissions have declined sharply for both the over-65 and under-65 populations. Total admissions declined 4.0 percent in 1984, after experiencing no change in 1982 and declining 0.5 percent in 1983. Admissions of patients under 65 years of age declined the most sharply in 1984: 4.5 percent. The change in admissions of patients over the age of 65 was also dramatic. After rising steadily for more than a decade, over 65 admissions declined 2.9 percent in 1984.

The second factor contributing to the slower increase in hospital expenses in 1984 was a continued decline in average length of stay. Lengths of stay have been declining for many years, with a recent acceleration in the decline. In 1984, the length of stay of patients under the age of 65 was 3.6 percent lower than the previous year. The length of stay of patients over the age of 65 declined 7.6 percent between 1983 and 1984.

The combined effect of shorter stays and fewer admissions has been a sharp reduction in hospital inpatient census.

The third major factor responsible for slower growth of expenses is a reduction in hospital employment made possible both by the lower census and by staffing efficiency improvement. Total full-time equivalent employees increased at rates of 3.7 and 1.4 percent in 1982 and 1983, repectively. In 1984, full-time equivalent employment declined 2.3 percent. Because admissions and length of stay declined, the number of staff hours per admission continued to rise, but at a lower rate of increase, 0.5 percent in 1984 compared to 3.4 percent in 1982 and 1.4 percent in 1983. This lower rate of growth is remarkable considering that the admissions which have been eliminated are probably lower-intensity cases.

Due largely to the slower growth of expenses, hospital-patient-service operating margins increased modestly from 1.0 percent in 1983 to 2.0 percent in 1984. While no one has reliable data on operating margins for Medicare and other payers, with one category separated out from the other, some anecdotal evidence suggests that Medicare has contributed to some extent to the improved financial picture. The anecdotal evidence also strongly suggests that the increase is extremely uneven. About half of the nation's hospitals have completed their first year under prospective pricing, and many of these hospitals are still in the process of reconciling their accounts and preparing their annual financial statements. HHS has yet to issue cost report forms for the first prospective pricing year. Consequently, few hospitals know with any degree of certainty if the implementation of prospective pricing has resulted in a net gain or a net loss. Even fewer hospitals would be able to identify the reasons for any gain or loss without more time for analysis.

Recent comments by the HHS Secretary have focused attention on hospital operating margins. Two comments are in order. First, in the new, more risky environment in which hospitals operate, the need for an operating margin has increased. In the past, when unforeseen events occurred which increased costs, these higher costs were generally recognized by Medicare and other cost-based payers. Under the new pricing systems, the hospital is at risk for higher costs, whatever the reason. Prior to starting their first prospective pricing year, hospital managers did not know what to expect; many prepared for the worst. By tightening up on staffing, intensively focusing internal medical review on length of stay, and prudently pricing services, most hospital managers hoped to provide a margin of safety, so that if the worst did occur, the hospital would be able to weather it. With the worst not so bad as many hospitals expected, there has been a modest strengthening of the financial position of the overall industry. This improvement enables hospitals to cope better with unexpected, and potentially catastrophic, events. Particularly in smaller hospitals, a single expensive case or a sudden unforeseen downturn in admissions can wipe out a hospital's operating margin for an entire year. A stronger financial position ensures continuity of services for both the hospital's patients and the community which the hospital serves.

The recent overall increase in operating margins should not be interpreted as evidence that hospitals are being overpaid or that Medicare prices were set "too high" to begin with. There has been no substantial jump in average revenue per case, as would have occurred if Medicare prices were initially set too high. Moreover, the recent downturn in admissions, together with the increasing complexity of the Medicare case mix, suggests that patients who are being admitted to hospitals today are more seriously ill, on average, than the patients admitted even last year. Perhaps most importantly, hospital financial performance varies substantially across groups of hospitals and among hospitals within any given group. Where financial performance has improved, it remains to be seen whether it will continue to do so.

CONCLUSION

The problem posed by the federal deficit is a serious one, one in which every group and every citizen has a direct interest. Hospitals are willing to contribute to solving the problem, particularly to a solution that is fair and even-handed. The HHS approach seems to ask for an inordinate contribution, relative to the participation of other sectors. This would be particularly harmful to vulnerable groups of institutions and beneficiaries. The AHA would like to see a more equitable approach, one that would protect the vulnerable, and offers its assistance to this Subcommittee in developing alternatives.

Chairman **STARK**. Dr. Mongan.

STATEMENT OF JAMES J. MONGAN, M.D., EXECUTIVE DIRECTOR, TRUMAN MEDICAL CENTER, KANSAS CITY, MO, ON BEHALF OF THE ASSOCIATION OF AMERICAN MEDICAL COLLEGES AND THE COUNCIL OF TEACHING HOSPITALS

Dr. **MONGAN**. Mr. Chairman, I am Dr. Jim Mongan, executive director of the Truman Medical Center in Kansas City, MO, a public teaching hospital. I am here on behalf of the Association of American Medical Colleges representing all of the Nation's medical schools and over 350 major teaching hospitals nationwide.

Mr. Chairman, we are intensely aware of the need for deficit reduction. And, in fact, America's hospitals, by cutting their rate of cost increase from 10.7 percent in 1983 to 4.6 percent in 1984, have already achieved budgetary savings beyond what the Administration had anticipated and projected.

But the administration's response to this record has been to propose a budget which would slash payments to hospitals further and which would cut most deeply into teaching hospitals and the patients they serve; 48.6 percent of the proposed reduction in hospital payments would come from these teaching hospitals, which we estimate receive about 25 percent of Medicare payments. In other words, those hospitals which serve the sickest and poorest of our citizens would be hit twice as hard as other hospitals by these inequitable proposals.

The specific proposals of concern to teaching hospitals are the following:

First, the arbitrary freeze on DRG prices, with no allowance for the impact of inflation or advances in health care technology.

Second, the reduction by one-half in the indirect teaching factor, a factor appropriately designed by this committee to cover the very real costs associated with the fact that teaching hospitals have a special mission and treat sicker patients.

And third, the permanent freeze in payments for direct medical education costs.

When these three proposals are combined with the phase-in provisions of present law which continue the march to a single arbitrary national payment rate, their inequitable impact is magnified. Many hospitals will face not only unfair freezes on reimbursement, but also dramatic reductions in actual payments from last year.

Mr. Chairman, let me turn from the abstract public policy debates of Washington, DC, to the very real world of Kansas City, MO.

Let me tell you what I have already had to do at my hospital to cope with the cuts in Medicare and Medicaid we have already faced.

First, we have done everything we can to increase our productivity. Looking back over 2 years, our volume of services has increased by 12 percent, due to the increase in people without insurance, and yet, our number of full-time equivalent employees has decreased by 7 percent. That is a dramatic increase in productivity and it was difficult to achieve. We are at the point where further cuts will have an adverse impact on services. I know, because I have already been forced to add back positions in respiratory therapy and intensive care nursing to maintain appropriate levels of care.

Second, we have already had to close certain programs and services, such as a drug abuse program and medical rehabilitation program.

And last, we have not been able to appropriately reinvest in our facility and our medical equipment, and in the long run, this will lead to the deterioration of our facility and the quality of care we can provide.

Mr. Chairman, we have cut the fat. Further deep reductions in revenue will force me to cut deeply into the bone and the quality of care I can provide will suffer.

The administration's budget proposals I outlined above would reduce our hospital's projected Medicare revenues by over $1 million next year. The budget proposals, combined with the move to an arbitrary national rate, would, in fact, actually slash our Medicare payments to a level 4 percent below what we are currently paid.

Mr. Chairman, just as Kansas City is reflective of the Nation—I believe my hospital is reflective of teaching hospitals—some would suffer more, some less, but all would suffer.

I don't believe this committee wants to destroy America's teaching hospitals, those hospitals that treat our sickest and poorest patients and train our future doctors, nurses and other health personnel.

Therefore, the Association of American Medical Colleges would recommend that you, first, amend the prospective payment system to halt the move to an arbitrary national rate by basing payments on a DRG specific blended rate or by freezing the transition at a 50-percent hospital specific and 50-percent regional cost rate.

Second, maintain the indirect teaching factor with some technical adjustments to increase its accuracy as a surrogate for the real cost of teaching hospitals.

Third, reject the permanent freeze on direct medical education costs, at least until a comprehensive assessment of graduate medical education is considered. And finally, reject the arbitrary freeze in DRG prices.

Mr. Chairman, America's teaching hospitals have cut the fat. We simply cannot withstand cuts twice as severe as those faced by other hospitals. We ask your help in seeking relief from these unfair proposals.

[The prepared statement follows:]

STATEMENT OF JAMES J. MONGAN, M.D., EXECUTIVE DIRECTOR, TRUMAN MEDICAL CENTER, KANSAS CITY, MO, ON BEHALF OF THE COUNCIL OF TEACHING HOSPITALS AND ASSOCIATION OF AMERICAN MEDICAL COLLEGES

The Association of American Medical Colleges which represents all of the Nation's medical schools, 73 academic societies, and over 350 major teaching hospitals participating in the Medicare Program, welcomes the opportunity to testify on the administration's fiscal year 1986 budget proposals for Medicare.

Once again this year, the Reagan administration is using the Federal budget process to propose major changes in the Medicare system for paying inpatient care. Three of their proposals are of significant concern to teaching hospitals:

The proposed freeze in the hospital-specific, regional, and urban prices used to determine DRG payments; the proposed 50-percent reduction in the so-called indirect medical education adjustment; and the proposed freeze in payments for direct medical education costs.

Each of these proposed changes would result in a substantial reduction in Medicare revenues for teaching hospitals; collectively, the resulting decrease in revenues by the three proposals would cause serious financial problems for teaching hospitals.

Using table 4 from the Ways and Means Committee print (WMCP-95-5), exhibits I and II show the financial impacts of the administration's proposals on Medicare payments to teaching hospitals. In fiscal year 1986, teaching hospitals would bear 48.6 percent of the proposed payment reduction. This rises to 59.4 percent of the reduction proposed for fiscal year 1990. As a result, the financial stability of many of the nation's teaching hospitals may be seriously weakened. Therefore, the Association of American Medical Colleges is compelled to speak out on the proposals and to state clearly its recommended policy position.

EXHIBIT I.—DOLLAR REDUCTION IN TEACHING HOSPITAL REVENUES UNDER ADMINISTRATION PROPOSALS FOR FISCAL YEAR 1986

[In millions of dollars]

	Total hospital reimbursement reduction	Teaching hospital reductions			
		DRG freeze[1]	Freeze direct medical education	Resident-to-bed adjustment	Total teaching hospital reduction
Fiscal year:					
1986	$2,665	$450	$150	$695	$1,295
1987	3,996	623$1,295	360	1,115	2,098

EXHIBIT I.—DOLLAR REDUCTION IN TEACHING HOSPITAL REVENUES UNDER ADMINISTRATION PROPOSALS FOR FISCAL YEAR 1986—Continued

[In millions of dollars]

	Total hospital reimbursement reduction	Teaching hospital reductions			
		DRG freeze [1]	Freeze direct medical education	Resident-to-bed adjustment	Total teaching hospital reduction
1988	4,543	637	530	1,430	2,597
1989	5,179	702	730	1,595	3,027
1990	5,840	771	940	1,760	3,471
Total	22,223	3,183	2,710	6,595	12,488

[1] Hospitals in the Council of Teaching Hospitals admitted 25 percent of all Medicare admissions to short-term, non-Federal hospitals in 1980. Estimate assumes these hospitals received 25 percent of Medicare hospital payments.

Source: WMCP: 99–5 "Description of the Administration's Fiscal Year 1986 Budget Recommendations under the Jurisdiction of the Committee on Ways and Means" with AAMC estimates for impact of the DRG freeze.

EXHIBIT II.—TEACHING HOSPITAL'S PERCENTAGE OF HOSPITAL REDUCTIONS UNDER ADMINISTRATION'S PROPOSALS FOR FISCAL YEAR 1986

[In percent]

	Percentage of total reduction from			
	DRG price freeze on teaching hospitals	Direct medical education payments	Resident-to-bed adjustment	Teachinghospitals
Fiscal year:				
1986	16.9	5.6	26.1	48.6
1987	15.6	9.0	27.9	52.5
1988	14.0	11.7	31.5	57.1
1989	13.6	14.1	30.8	58.4
1990	13.2	16.2	30.1	59.4
Total	14.3	12.2	29.7	56.2

Teaching hospital impact only.

Source: WMCP: 99–5 "Description of the Administration's Fiscal Year 1986 Budget Recommendations under the Jurisdiction of the Committee on Ways and Means" with AAMC estimates for impact of the DRG freeze.

DIRECT MEDICAL EDUCATION COSTS

To provide clinical training for residents, nurses, and allied health personnel, hospitals incur costs beyond those necessary for patient care. Since its inception, Medicare has paid its share of these added direct expenses on a cost reimbursement basis. Under prospective payment, cost reimbursement for these expenses is continued using the "direct medical education passthrough."

The justification for this passthrough was clearly described in the Secretary's 1982 report "Hospital Prospective Payment for Medicare" (pp 47–48): The Department believes that the direct costs of approved medical education programs should be excluded from the rate and be reimbursed as per the present system. This approach will assure that the base rate is related to a patient care outcome and not significantly influenced by factors whose existence is really based on objectives quite apart from the care of particular patients in a particular hospital.

Congress supported the Department's position that it was not appropriate to include clinical training costs in the DRG payment and approved continuing to pay the costs of graduate medical education on a cost-reimbursement basis separate from the DRG based per case payment.

Medicare's share of the direct medical education passthrough is determined using generally accepted accounting principles and Medicare reimbursement regulations. The hospital accounting system accumulates expenses directly associated with these activities in specific cost centers. For example, hospital expenses for resident stipends are recorded in the graduate medical education (or intern and resident) cost center. After all expenses are entered, overhead expenses—such as administration, maintenance, and utilities—are allocated (or apportioned) across the Medicare recognized cost centers such as graduate medical education. Thus, the cost being reimbursed through the direct medical education payment includes expenses incurred by the cost center and allocated overhead.

Reducing Medicare support by permanently freezing the passthrough as the Administration recommends will weaken graduate medical, nursing, and allied health education programs. It will also set a precedent which other payers may cite as the basis for reducing their support. Rather than having deficit reduction politics determine future health manpower policy, the AAMC believes that public policy on financing graduate medical education should be fully debated and resolved prior to altering the current passthrough. Therefore, the Association of American Medical Colleges is strongly opposed to any change or reduction in the passthrough for direct medical education costs until a comprehensive assessment of financing graduate medical education is completed and fully considered.

INDIRECT MEDICAL EDUCATION ADJUSTMENT

In 1980, the then-effective Medicare routine service limits included a passthrough for graduate medical education costs. An HHS analysis showed that, even with the passthrough, teaching hospitals were disproportionately penalized by the limit. Further HHS studies revealed that the likelihood of being penalized was directly related to a teaching hospital's ratio of residents to beds. Using these findings, HCFA modified the limit to include an adjustment for the higher patient care costs found to be statistically associated with a hospital's resident-to-bed ratio. The initial adjustment was set at 4.7% for each 0.1 resident per bed. When the routine limits were replaced by the more-inclusive TEFRA limits, the resident-to-bed adjustment was retained but recalculated at 6.06% for every 0.1 resident per bed.

The Secretary's report on "Hospital Prospective Payment for Medicare" proposed an adjustment in DRG payment rates based on the ratio of residents-to-beds in teaching hospitals (pp 48–49).

"The indirect costs of graduate medical education are higher patient care costs incurred by hospitals with medical education programs. Although it is not know precisely what part of these higher costs are due to teaching (more tests, more procedures etc.), and what part is due to other factors (the particular types of patients which a teaching hospital may attract), the Medicare cost reports clearly demonstrate that costs per case are higher in teaching hospitals.

"It is also clear that the mere presence of interns and residents in an institution puts extra demands on other staff and leads to the existence of higher staffing levels. The process of graduate medical education results in very intensive treatment regimens. Again, the relative importance of the various reasons for the higher costs observed in teaching hospitals is difficult to identify precisely. However, there is no question that hospitals with teaching programs have higher patient care costs than hospitals without.

"The Department believes that recognition of these indirect costs should be accomplished through a lump-sum payment, separate and distinct from the base rate. This adjustment will be computed using methods that are similar to the methods currently used to adjust the old routine and new total cost limits for the indirect costs of graduate medical education. The hospital's cash flow will be preserved by some sort of periodic payment."

As this Subcommittee considered the proposed Medicare prospective payment system early in 1983, the Congressional Budget Office [CBO] prepared estimates of the impact of the new payment system on different types of hospitals. Hospitals were compared on the basis of region, urban/rural location, bed size, ownership and teaching status. CBO estimates showed that teaching hospitals would suffer disproportionate revenue losses under the proposal and that the amount of the loss would be relatively greater for hospitals with at least .25 residents per bed than for hospitals with lower resident-to-bed ratios.

Because CBO analysis showed that the Department's proposed adjustment did not provide equitable treatment for tertiary care/teaching hospitals, the Subcommittee on Health of the Ways and Means Committee asked CBO staff to estimate prospective payment impacts using a doubling of the Department's proposed adjustment. The resulting estimates showed teaching hospitals would be benefited or penalized under the new system in approximately the same proportion as non-teaching hospitals. Thus, a doubling of the proposed resident-to-bed adjustment provided the desired equity between teaching and non-teaching hospitals.

Congress, and most particularly this Subcommittee and its parent Committee, clearly recognized the multiple deficiencies the adjustment would help correct.

"Your Committee strongly believes in the importance of providing this adjustment in the light of serious doubts (explicitly acknowledged by the Secretary in his recent report to the Congress on prospective payment) about the ability of the DRG case classification system to account fully for factors such as severity of illness of patients requiring the specialized services and treatment programs provided by teaching institutions and the additional costs associated with the teaching of residents.

"The latter costs are understood to include the additional tests and procedures ordered by residents as well as the extra demands placed on other staff as they participate in the education process. Your Committee emphasizes its view that these indirect teaching expenses are not to be subjected to the same standards of "efficiency" implied under the DRG prospective system, but rather that they are legitimate expenses involved in the postgraduate medical education of physicians which the medicare program has historically recognized as worthy of support under the reimbursement system.

"The adjustment for indirect medical education costs is only a proxy to account for a number of factors which may legitimately increase costs in teaching institutions. Your Committee believes that it is important, in addition, to recognize explicitly extraordinary expenses in individual cases, and has therefore required (as discussed elsewhere) an expansion and modification of the Secretary's recommended policy regarding atypical cases or outliers (which is reasonable to expect would occur more commonly in teaching hospitals than in other hospitals)." (House Report 98-25).

In the AAMC's judgment, the resident-to-bed ratio serves as a proxy to adjust for inadequacies in prospective payment, including:

Inadequate recognition of differences within a DRG of the complexity of disease, intensity of care required and resources utilized for patients in the teaching hospitals;

No recognition for the teaching hospital's costs of maintaining both a broader scope of services and the capacity to provide specialized regional services;

Failure of the wage adjustment to account for differences between central city and suburban wage rates within metropolitan areas;

Decreased productivity which results from including trainees in the hospital programs; and

Additional ancillary services ordered by trainees involved in the diagnosis and treatment of patients.

Thus, while the resident-to-bed adjustment is called the "indirect adjustment for costs accompanying medical education," it is, in fact, a proxy measure to provide appropriate compensation for the added patient service costs borne by teaching hospitals. Nevertheless, its "medical education" label permits the adjustment to be viewed as an educational payment rather than a correction for statistically consistent differences in cost between teaching and non-teaching hospitals. The AAMC is concerned about this misperception.

The resident-to-bed or indirect medical education adjustment was originally developed to create a "level playing field" for teaching and non-teaching hospitals under prospective payment. Unfortunately, old and often incorrect data on resident numbers, bed complement, wage rates, and DRG case mix were used in estimating the adjustment. In addition, two variables not included in the final payment system, bed estimated an equation based only on the factors used in prospective payment to vary DRG prices and with up-to-date, accurate data. Therefore, the Association of American Medical Colleges supports recomputing the resident-to-bed adjustment using current hospital resident and bed data, up-to-date corrected hospital case mix indices, corrected wage indices, and a regression equation which incorporates only variables used in determining hospital DRG payments.

Attached to the testimony is a copy of a more detailed study of the resident-to-bed adjustment prepared by Judith Lave, Ph.D. HCFA's former research director and currently a professor of health economics at the University of Pittsburgh.

Before continuing, the AAMC does wish to briefly describe the relationship between the resident-to-bed adjustment and the issue of hospitals caring for disproptional number of the indigent. The regression estimate used for the resident-to-bed adjustment attempts to account for differences in hospital costs which are consistently related to the number of residents per bed. Because teaching hospitals treat more severly ill patients requiring more intensive services, the equation helps adjust for this difference.

At a given level of severity, indigent patients need and use more services than non-indigent patients. Because teaching hospitals, as a group, care for a disproportional number of indigent patients, the resident-to-bed calculation provides some adjustment for this factor. It should be noted, however, that medical education activity is not a particularly good estimator of the cost burden of care to indigent patients. Some teaching hospitals care for a disproportional number of indigent patients; others do not. In this circumstance, a separate indigent care adjustment should be established to acknowledge the cost impact of the more severely ill indigent patient.

Price blending

In enacting the prospective payment system, Congress wisely included a phased transition so (1) that the hospital-specific payment component would provide hospitals with some protection against inherent weaknesses in the system and (2) that policy could be changed before the weaknesses caused major damage. Those weaknesses are already coming to light: HCFA's data show that many DRGs include patients with lighly varying costs while other DRGs have a relatively small variation in costs, geographic regions have consistent but poorly understood differences in hospital operating costs, and "dumping" of economically undesirable Medicare patients is on the increase. To minimize the adverse impacts of these weaknesses while providing hospitals with an incentive for efficiency, the AAMC strongly recommends replacing the original price blending formulas with a new approach which blends a hospital-specific price component and a Federal average price component using the observed variation in DRG cost. Where data show hospitals care for patients in a given DRG at relatively consistent costs, the DRG payment would depend heavily on the Federal price component. On the other hand, where data show hospital costs for patients in a given DRG vary widely, the DRG payment would be based primarily on the hospital-specific price component.

The Association of American Medical Colleges strongly recommends that Congress amend the prospective payment system so that payments are based on a DRG specific, blended rate of hospital-specific and Federal component prices.

If Congress is unwilling at this time to adopt a long-range solution, such as DRG specific blending recommended above, an interim approach that would moderate both "windfalls" and catastrophes would be to set payments based on a blend of hospital-specific and average prices. A 50/50 blend would provide both strong economic incentives for improved management and an economic safety net against shortcomings in the initially enacted system.

For the Federal component, the regional average should be retained. At the present time, it is not clear why urban hospitals in New England, the Great Lakes, the Northern plains, and the Pacific states have costs above the national average. Absent an understanding of the higher costs in the regions and with no clear evidence that hospitals in these four regions are less efficient than those in the other five regions, it seems premature to move to prices set using the national average. Therefore, if Congress is unwilling to enact DRG specific price blending, then the association of American Medical Colleges recommends that Congress amend the DRG price formula so that it is based on a blend of 50 percent hospital-specific costs and 50 percent regional average costs.

Price freeze

The prospective payment system was enacted to encourage hospitals to reduce costs. Every available piece of evidence indicates hospitals are responding by reducing their costs. Moreover, and contrary to those who felt the system would be manipulated, hospitals have also experienced a drop in admissions. Clearly, hospitals have responded to the national mandate. In an economy that is still experiencing significant inflation and with a Medicare population that includes growing numbers of the very old and the frail elderly, the AAMC believes it is inappropriate to impose a price freeze and ignore the increased costs hospitals must incur for the personnel, goods, and services they buy. Therefore, the Association of American Medical Colleges vigorously opposes any freeze in DRG prices.

Conclusion

Teaching hospitals are a diverse group of highly complex institutions performing medical education and research services for the nation and providing both basic and tertiary patient care. The current emphasis on re-examining national policies in light of more limited public resources places teaching hospitals and their vital activities at significant risk if their special nature and role are not appreciated. As policies and expectations change, teaching hospitals will continue to adapt and evolve. If developing national policies on health care delivery and payment recognize the distinctive characteristics and diversity of teaching hospitals, their fundamental missions can be preserved. If the characteristics of teaching hospitals are not recognized and valued, simplistic public policies may damage the ability of these institutions to fulfill their multiple responsibilities.

If the Medicare prospective payment system is to provide hospitals with an appropriate incentive for efficiency, methodological weaknesses must be eliminated, inaccurate data must be corrected, and real differences in the cost of various types of hospitals should be recognized. the AAMC recommendations have been developed to provide a more reasonable and equitable prospective payment system than that recommended in the Administration's budget proposal.

Chairman STARK. Mr. Gage, who is pinch-hitting for William Pinkston of the Grady Memorial Hospital. We have Mr. Pinkston's testimony. Are you going to summarize for us?

STATEMENT OF LARRY GAGE, REPRESENTING WILLIAM PINKSTON, EXECUTIVE DIRECTOR, GRADY MEMORIAL HOSPITAL, ATLANTA, GA, ON BEHALF OF THE NATIONAL ASSOCIATION OF PUBLIC HOSPITALS

Mr. GAGE. I apologize on behalf of Mr. Pinkston. He was unable to make it at the last moment, due to the death of a close friend, and he asked me to appear on his behalf.

I will briefly summarize the prepared testimony you already have. In point of fact, since Jim Mongan is also a very good board member of NAPH, he has already summarized one-half of what I had planned to say. I will therefore focus very briefly, as Bill was intending to do, on the specific situation at Grady Memorial Hospital, rather than concentrating on the national situation, since it is too rare that the committee gets to hear about the impact of its programs on individual hospitals.

Grady Memorial Hospital is part of a situation in the State of Georgia that could, over time, spell disaster for low-income patients. The Georgia Medicaid Program is not one of the best in the country to begin with. It is one of the best in the South, but Georgia has recently held back on some improvements in its Medicaid Program that were enacted last year, pending the outcome of debate here in Washington over the Federal Medicaid cap.

NAPH did a study for the Georgia Hospital Association earlier this year in which we detail the overall situation in the State with regard to uncompensated care. While I know that is not the primary focus of your hearing today, I will summarize those findings, because they are crucial to your consideration of the impact of the Medicare cuts that are proposed on the disproportionate share hospitals. NAPH represents nationally those hospitals that like Grady, have the most significantly disproportionate share of low-income patients.

Medicaid coverage in Georgia is presently unavailable to 54 percent of the persons in the State with incomes below the poverty level, or about 800,000 individuals. We also estimate that over 1 million individuals in Georgia with incomes below 150 percent of the Federal poverty line are uninsured, for a total of 1.8 million Georgians, or over one-third of the State's population.

This does not include low-income patients with Medicare coverage who, if not eligible for Medicaid or unable to purchase Medigap insurance, must also be considered uninsured as well.

There are 167 hospitals in the State of Georgia, with 31,000 beds, and we estimated that these hospitals in the aggregate provided $231 million in uncompensated care in 1982.

However, just seven major tertiary teaching hospitals in the State, some public and some private, located largely in Georgia's SMSA's, provided 44 percent of all of that uncompensated care, or $102 million.

Those seven hospitals have just 13 percent of the beds in the State of Georgia.

Finally, the NAPH study found that just one hospital alone accounted for 17.8 percent of the entire uncompensated care burden, or $46 million, in the State of Georgia. This amount is subsidized to a large extent, although by no means entirely, by the taxpayers of Fulton and DeKalb Counties.

That hospital is Grady Memorial Hospital.

Grady Memorial Hospital, thus reflects, as does the Truman Medical Center and most of the rest of our members, the true situation of the "disproportionate share" health care safety net or situation now dramatically worsening due to a combination of public and private actions and trends.

Grady is the largest general hospital in Georgia, 960 beds, revenues exceeding $115 million. Over 60 percent of its revenues come from direct city-county appropriations and Medicaid, and Medicare accounts for another 21 percent. Just 9.7 percent of Grady's revenues are derived from privately insured patients.

Grady had over 800,000 outpatient visits in 1984, another fact of life for disproportionate share hospitals, which provide a substantial amount of outpatient care, far in excess of any other segment of the hospital industry.

Grady has a number of highly specialized tertiary care centers, including a burn center, maternal high-risk program, and a variety of others.

Grady is also a significant teaching hospital, training over 300 residents per year.

Grady has estimated the impact of the freeze on its programs. If the legislation proposed by the President is passed in its present form, Grady will lose $900,000, based on the freeze by itself.

If the direct medical education provision is adopted, Grady will lose another $125,000. If you reduce the indirect medical education factor, as the administration proposes, Grady will lose approximately $4 million more.

As you can see, the changes will cost this one hospital which serves so many poor people, about $5 million. The fact remains that this is a hospital which has simply never experienced the PPS system as it was intended by Congress to be applied.

When Congress first passed the PPS legislation, and for that matter, when Congress passed the TEFRA legislation in 1982, Congress asked that special attention be paid to the needs of hospitals in a situation like Grady.

That provision was never implemented, and as a result, we have been forced to take the administration to court over this issue. I think we must ask this committee, even if none of the President's proposals are adopted, to insist that this provision be implemented.

In addition, we feel very strongly that the direct medical education and the indirect medical education provisions are essential to public teaching hospitals, and that public teaching hospitals operate in a variety of ways essentional to the health system—not just a number of specialized programs, not just medical education and not just care to the poor, but an essential combination of all three.

Finally, we believe, as the AARP stated earlier, it is extremely important not to further impact the beneficiary in the proposals before you today. For low-income Medicare beneficiaries who use our hospitals, that reduction is a hardship that will be directly passed on to our hospitals, and also will affect the bottom line.

[The prepared statement follows:]

STATEMENT OF J.W. PINKSTON, JR., EXECUTIVE DIRECTOR, GRADY MEMORIAL HOSPITAL, ATLANTA, GA, ON BEHALF OF THE NATIONAL ASSOCIATION OF PUBLIC HOSPITALS

I. INTRODUCTION

Mr. Chairman, members of the Subcommittee, I am J.W. Pinkston, Jr., Executive Director of Grady Memorial Hospital, Atlanta, Georgia. Grady is a 960 bed public teaching hospital owned and operated by the Fulton-Dekalb Hospital Authority, a public corporation. I also serve as Secretary of the Board of Directors of the National Association of Public Hospitals, and I am accompanied this morning by Larry S. Gage, President and General Counsel of that organization. NAPH consists of 50 public hospitals and hospital systems that serve as major referral centers and hospitals of last resort for the poor of our Nation's largest metropolitan areas.

We appreciate the opportunity to participate in these hearings today. We are particularly grateful that your Subcommittee has been among the most important and vocal advocates for hospitals like Grady, that have come to be known as "disproportionate share hospitals", and for the low income patients we serve. NAPH was founded over four years ago, with uncompensated care and the situation of "disproportionate share hospitals" as our most important priorities. Virtually every action we have undertaken in the last four years has had the goal of achieving access to high quality care for all of our nation's citizens, regardless of their ability to pay or the nature or severity of their illness.

Your increased attention to these matters over the last several years has been essential, because substantial changes in public and private reimbursement systems—ranging from the Medicare prospective payment system to the growth of HMOs, PPOs, and other alternative delivery systems—have significantly increased the pressure on "disproportionate share hospitals". The "cost shift", which had previously served to help subsidize care for uninsured or underinsured patients, for all practical purposes is disappearing in the face of strenuous demands by all payers for cost containment. But in our rush to contain costs and curb hospital inflation, we must recognize that not every cost previously shifted was due to inefficiency or waste. Many such costs are legitimate, including the costs of providing so-called "uncompensated care"; the costs of educating future generations of health care professionals; and the costs of biomedical research and essential preventive and primary health services. Yet even those essential services are increasingly being left by our system to be borne by local governments, by taxpayers, by "disproportionate share hospitals", by the low income patients themselves, or by no one at all.

For these reasons, our position on the President's proposed budget reductions for health may tend to sound overly simplistic. Quite simply, we oppose them—all of them—from the proposed Medicare freeze and Medicaid cap, to reductions in the direct and indirect teaching adjustments, to increased deductibles and copayments for beneficiaries. From our unique vantage point as disproportionate share hospitals, we believe *any* of these proposed reductions will have a harsh and cumulative impact on our institutions—an impact many of us have already begun to feel.

To summarize our position, we believe the cumulative effect of various reforms undertaken by both public and private payors in our nation's health system today puts "safety net" hospitals like Grady Memorial in particular jeopardy. We do not believe the health system can easily afford to give up our hospitals at this time of great instability. The members of this Committee have understood this fact for the last several years, but unfortunately the Reagan Administration has not. Even if you do not adopt any of the President's proposals, we must ask that you insist once again on implementation of the Medicare provisions you have already adopted several times to protect "disproportionate share hospitals". The Secretary has thus far refused to implement any of these provisions. I will discuss in greater detail below why we believe this is a vital step you must take again this year—one that is necessary whether or not any further reductions are made in the Medicare program.

The remainder of my testimony will be divided into three parts, which will provide more detailed information in support of our general position:

In Part II, I will seek to bring the Committee up-to-date on the current situation of public hospitals nationally, including new data comparing the fiscal, demographic and health services delivery situation of metropolitan area public hospitals with other types of hospitals, and the impact on public hospitals and other "disproportionate share" providers of the PPS system.

In Part III, I will review for you the current situation with regard to uncompensated care and "disproportionate share hospitals" in the State of Georgia, and with regard to Grady Memorial in particular. In that regard, I will pay particular attention to the delivery of health services to low income persons in a state with inadequate Medicaid coverage, including the impact on that system of the growing trends in the health industry toward prospective payment, competition, entrepreneurialism, and the "bottom line" fiscal mentality in health care delivery and financing.

Finally, in Part IV, I will discuss the Secretary's failure to implement the Congressionally mandated "disproportionate share hospital" adjustment.

II. THE SITUATION OF PUBLIC HOSPITALS IN AMERICA TODAY

A. General overview

NAPH has described our nation's public hospital system in considerable detail in previous testimony before this Committee. However, we have not appeared before this Committee in several months. I therefore believe it is appropriate in the context of this hearing to describe again in some detail several key service delivery and financing elements common to America's "safety net" hospitals, and direct your attention to a number of new studies which shed further light on the role and situation of public hospitals in our nation today.

This nation has repeatedly considered enacting National Health Insurance and it may yet be possible for us to design "solutions" for the problem of uncompensated care that permit all of our nation's citizens access to every doctor and every hospital in our system. Until that time, however, we must acknowledge that there presently exists a nationwide network of institutions, a mere handful of metropolitan area public and private hospitals, that provide and finance many of the services needed and used today by uninsured individuals. We believe the federal government must take steps to protect and preserve that network.

With regard to specific data in support of this general observation, NAPH has conducted and analyzed other new surveys and analyzed new data in the last several months to augment the information we have provided to this Committee in the past. We have conducted an intensive analysis of data collected by other researchers, such as the Urban Institute's survey of 1,700 hospitals, which focused on the extent of medical care for the poor and the financial status of hospitals serving the poor. A summary of the information we have been developing and analyzing is likely to be helpful in understanding the situation of public hospitals today.

B. National public hospital data

1. Public hospitals continue to take all patients—regardless of ability to pay.

Where public hospitals exist, they are "de facto" national health insurance today. According to a 1983 NAPH survey, uncompensated care represented an average of 29 percent of 1982 inpatient days for NAPH member hospitals (or an average of 46,010 uncompensated inpatient days per hospital). Forty-six percent of all outpatient/emergency room visits to NAPH members, on average, were also uncompensated (106,000 uncompensated care visits per hospital).

It should be noted that NAPH member hospitals maintained this "open door" while serving as an essential source of care for many insured patients as well, with each hospital averaging over 158,000 inpatient days and over 229,000 outpatient/emergency room visits by Medicare, Medicaid and privately insured patients. In 1983 alone, just 40 NAPH member hospitals accounted for 789,000 inpatient admissions and over 9 million outpatient and emergency room visits.

How does this effort compare with other sectors of the hospital industry? AHA/Urban Institute Survey data enables us to compare the relative levels of care to the poor rendered by various categories of hospitals. In Table I, data are presented for hospitals, by ownership and geographical location, indicating relative proportion of charity care, bad debt and Medicaid for 1,700 of the Nation's hospitals. The Urban Institute believes these data are sufficiently comprehensive to permit extrapolation of these trends to the Nation's 5,700 acute care hospitals.

This table shows that hospitals in the 100 largest metropolitan areas accounted for most of the charity care (63 percent) and care to Medicaid clients (54 percent) and almost half of the bad debt (48 percent) incurred in the Nation. Although public hospitals in those 100 cities represent only 5 percent of all hospital beds, their proportion of charity care—40.3 percent—far exceeded the next highest group. Nonprofit hospitals in these cities as a group provided 22.5 percent of the charity care—with over 26 percent of the hospital beds. The primary low income patient group in those hospitals was Medicaid recipients.

TABLE I.—HOSPITAL CARE TO THE POOR BY OWNERSHIP AND LOCATION

[Dollar amounts in millions]

	Total hospitals	Beds (percent of total)	Total poor care		Charity care		Bad debt		Medicaid	
			Amount	Percent	Amount	Percent	Amount	Percent	Amount	Percent
Universe	[2] 5,719	[3] 971,738	$14,389.1	100.0	$1,849.8	100.0	$3,494.3	100.0	$9,045.1	100.0
(A) 100 largest Cities	973	34.6	7,744.8	53.8	1,163.2	62.9	1,689.1	48.3	4,892.5	54.0
Public	100	5.0	2,499.1	17.4	745.1	40.3	672.9	19.3	1,081.1	12.0
Nonprofit	681	26.6	4,903.3	34.1	416.4	22.5	901.9	25.8	3,585.0	39.6
Proprietary	192	3.0	342.4	2.3	1.7	.1	114.3	3.3	226.4	2.5
(B) Other SMSA [1]	1,831	39.6	4,793.5	33.3	531.2	38.7	1,214.6	34.6	3,047.8	33.7
Public	366	6.8	1,187.6	8.2	216.7	11.7	332.6	9.5	638.3	7.0
Nonprofit	1,159	28.6	3,098.5	21.5	310.7	16.8	710.1	20.3	3,077.1	23.0
Proprietary	306	4.2	507.4	3.5	3.8	.2	171.9	4.9	331.8	3.7
(C) Non-SMSA	2,915	25.9	1,850.8	12.9	155.4	8.4	590.6	16.9	1,104.7	12.2
Public	1,317	9.5	676.6	4.7	63.0	3.4	261.1	7.5	352.6	3.9
Nonprofit	1,366	14.6	1,064.9	7.4	88.7	4.8	307.1	8.8	669.1	7.4
Proprietary	232	1.7	109.2	.8	3.7	.2	22.4	.6	83.1	.9

[1] Standard Metropolitan Statistical Area.
[2] Extrapolated from 1,700 hospital sample.
[3] 100 percent.

Source: NAPH analysis of AHA/Urban Institute data.

Bad debt in public hospitals was, by bed size, proportionately four times greater than in non-profit facilities. In addition, metropolitan area public hospitals averaged over $10 million each in Medicaid care, compared to an average of $5.3 million for non-profit facilities. Proprietary facilities in large cities provided an insignificant amount of charity care (0.1 percent) and experienced very little bad debt and Medicaid care (3.3 and 2.5 percent respectively).

In non-SMSA areas, although the amounts per bed were smaller, public hospitals provided 42 percent more charity and bad debt per bed than did non-profit hospitals and 135 percent more than did proprietary hospitals. Large urban public hospitals provided 358 percent more free care per bed than the average large city non-profit hospital, and provided 1,006 percent more free care per bed than the average large city proprietary hospital in 1982.

Total utilization comparisons of NAPH members and AHA-member hospitals between 1981 and 1983 reveal some striking differences. While admissions at U.S. hospitals declined slightly (0.8 percent) for this period, NAPH institutions witnessed a marked increase in their admissions (9.4 percent). A slight 1.0-percent increase in occupancy rates for NAPH member hositals also occurred during this 2-year period (from 73.3 to 74.3 percent). What makes this funding so important, however, is the dramatic drop in occupancy rates in U.S. community hospitals between 1981 and 1983—from 76.0 to 73.5 percent. Thus urban public hospitals are continuing to increase their occupancy rates to a level that, as of 1983, has surpassed the average for the country's institutions.

2. Despite the persistent Washington, D.C. myth that cities and counties are not paying their way, a substantial portion of the public hospital budget comes from local tax revenues.

Table II presents the sources of revenue for 41 of our institutions during 1983, demonstrating both their size and their disproportionate reliance on state and local government support. As indicated, these resources accounted for over 30 percent of the $4.2 billion in revenues. (Actually, these sources' contributions are probably much higher, since the 15.8 percent in revenues under "other", in general, are related to state and local support). The State-Federal support through Medicaid is also very substantial (25 percent) in as is the proportion of Medicare (16.7). As expected, private insurance, both Blue Cross and commercial, represents the lowest source of NAPH member revenue (15.8 percent). These findings are not aberrations but, rather, are indicative of the support patterns for NAPH members since the late 1970's.

TABLE II.—SOURCES OF REVENUE FOR NAPH MEMBER HOSPITALS IN 1983 [1]

[Dollar amounts in millions]

Hospital	Total	Medicare		Medicaid		City/county and State appropriations		Private insurance		Other	
		Amount	Percent	Amount	Percent	Amount	Percent	Amount	Percent	Amount	Percent
Alameda	$71.8	$9.2	12.8	$24.4	34.0	$26.7	37.2	$3.4	4.7	$8.1	11.3
Amarillo	57.1	9.6	16.8	2.2	3.9	8.1	14.2	34.3	60.1	2.9	5.1
Bellevue	195.0	33.1	17.0	84.8	43.5	42.5	21.8	14.4	7.3	20.2	10.4
Brackenridge	77.0	21.7	28.2	4.9	6.4	4.9	6.4	45.2	58.7	.3	.4
Bronx Municipal	143.8	34.4	23.9	57.6	40.0	27.3	19.0	11.8	8.3	12.7	8.8
Charity Hospital of New Orleans	131.7	17.8	13.5	18.3	13.9	89.0	67.6	([3])		6.6	5.0
Chope Community	25.0	4.9	19.6	5.6	22.4	6.2	24.8	3.3	13.2	5.0	20.0
Cleveland Metropolitan General/Highland View Hospital	168.4	41.2	24.5	51.9	30.8	20.4	12.1	([3])		[2] 54.9	32.6
Contra Costa County	44.6	8.8	19.7	16.0	35.8	12.7	28.4	1.4	3.1	5.7	12.7
Cook County	212.2	21.5	10.1	54.0	25.4	115.3	54.3	17.1	8.1	4.4	2.1
Dallas County Hospital District	193.9	24.4	12.5	10.8	5.5	64.7	33.3	35.9	13.3	68.1	35.1
D.C. General	112.6	16.9	10.9	27.7	17.8	39.1	25.1	8.4	5.4	20.5	18.2
Fresno Valley Medical Center	85.5	19.6	22.9	39.3	46.0	5.6	6.5	9.3	10.9	11.7	13.7
Grady Memorial	112.6	23.6	21.0	25.2	22.4	41.8	37.1	10.9	9.7	11.1	9.9
Harbor/UCLA	108.9	13.0	11.9	49.8	45.7	23.3	21.4	14.8	13.6	8.0	7.3
Harborview Medical Center	68.2	17.0	24.9	24.3	35.6	7.0	10.3	5.1	7.5	14.8	21.7
Harlem	144.5	29.4	20.4	44.8	31.0	57.0	39.4	5.6	3.9	7.7	5.3
Hurley Medical Center	81.9	30.7	37.4	22.7	27.7	0	0	14.9	18.1	13.6	16.6
Kern Medical Center	41.3	5.3	12.8	18.8	45.5	8.9	21.5	7.0	16.9	1.3	3.1
King/Drew Medial Center	119.6	2.2	1.8	24.9	20.8	72.6	60.7	5.0	4.1	14.9	12.4
Los Angeles County/USC Medical Center	350.2	14.3	4.1	111.2	31.7	173.5	49.5	7.2	2.1	44.0	12.5
Maricopa Medical Center	90.7	16.7	18.4	0	0	13.3	14.7	.2	.2	60.5	66.7
Memorial Medical Center	100.8	33.4	33.1	10.4	10.3	3.9	3.9	30.4	30.2	22.7	22.5
Queens Hospital Center	98.3	20.4	20.8	34.8	35.4	27.9	28.4	6.6	6.7	8.6	8.7
R.E. Thomason	32.2	4.0	12.4	2.7	8.3	10.7	33.2	7.6	23.6	7.2	22.3
Regional Medical Center	82.0	9.8	7.3	21.9	16.3	28.0	20.9	3.6	2.7	18.7	22.8
Riverside	41.2	4.8	11.6	18.0	43.6	6.1	14.8	5.0	12.1	7.3	17.7
St. Louis County	25.3	5.3	20.9	3.9	15.4	13.2	52.2	1.5	5.9	1.4	5.5
San Bernadino	64.5	12.0	18.6	23.6	36.6	6.4	9.9	4.4	6.8	18.1	28.1
San Francisco General	112.6	18.4	16.3	31.4	27.8	47.7	42.3	10.1	8.9	5.0	4.4
San Joaquin	32.1	5.6	17.4	14.2	44.2	6.1	19.0	2.4	7.4	3.8	11.8
Santa Clara Valley Medical Center	98.9	20.5	20.7	37.3	37.7	91.0	19.2	21.3	21.5	.8	.8

TABLE II.—SOURCES OF REVENUE FOR NAPH MEMBER HOSPITALS IN 1983 [1]—Continued

[Dollar amounts in millions]

Hospital	Total	Medicare		Medicaid		City/county and State appropriations		Private insurance		Other	
		Amount	Percent	Amount	Percent	Amount	Percent	Amount	Percent	Amount	Percent
Truman Medical Center	60.5	12.6	20.8	14.7	24.3	19.2	31.7	8.0	13.2	6.0	9.9
University Hospital of Cincinnati	124.8	29.9	24.0	13.7	11.0	14.5	11.6	39.0	31.2	27.8	22.2
University Hospital of New Jersey	123.3	13.1	10.6	25.6	20.8	15.0	12.2	14.2	11.5	55.4	44.9
University of New Mexico Hospital	59.0	12.5	21.1	9.3	15.7	6.9	11.6	17.8	36.1	12.5	21.1
University of Texas Health Center (Tyler)	29.5	8.2	27.7	.3	0	18.0	61.1	3.0	10.2	0	0
University of Texas Medical Branch (Galveston)	191.5	21.0	11.0	5.6	3.0	134.2	70.0	25.3	13.2	5.4	2.8
Ventura County	44.5	5.1	11.4	14.1	31.6	4.3	9.6	21.0	47.1	0	0
Westchester County Medical Center	113.7	22.1	19.4	32.3	28.4	12.7	11.2	30.8	27.1	15.8	13.9
Wishard Memorial	132.4	26.2	19.1	18.7	13.6	21.0	18.9	17.0	12.4	49.5	36.0
Total revenues	4,205.6	702.2	16.7	1,051.7	25.0	1,274.7	30.3	514.2	12.2	663.0	15.8

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[1] Sources: NAPH Survey of Hospital Characteristics, The California Association of Public Hospitals, the California Health Facility Commission and individual California Public Hospitals Provided information on California institutions. Amounts are gross patient revenues or changes. Number of hospitals: 41.

[2] Includes private insurance.

[3] Not available.

3. The non-Medicaid uninsured caseload of public hospitals has substantially increased in recent years.

The August 1983 NAPH survey of unemployed and uninsured patients in public hospitals demonstrated that these facilities are now the source of health care for thousands of individuals who had relied on other health services before unemployment. Forty-four percent of the unemployed patients surveyed responded that they had not used the public hospitals as a regular source of care before becoming unemployed. Eight hospitals reporting inpatient and outpatient data had a total of 5506 unemployed and uninsured visits or admissions for a seven day period—an average of 688 per hospital. If this number is projected is annualized, these eight institutions alone would experience over 280,000 visits and inpatient days by uninsured and unemployed patients.

The newly unemployed comprise just one part of the increased indigent caseload of public hospitals in metropolitan areas. The problem is substantially exacerbated by reductions in Medicaid eligibility, and inadequate funding for special populations such as illegal aliens and refugees. Moreover, we believe we can also anticipate a significant increase in more severely ill Medicare patients, as private hospitals move to adjust their caseload to maximize reimbursement under the new DRG system.

NAPH data for 1982 shows that just 17 public hospitals attributed 917,120 inpatient days to bad debt or charity care, or nearly 54,000 per hospital. expenditures for unreimbursed inpatient care for just 20 of our members totalled $379 million in 1982, or nearly $19 million per hospital.

4. Public hospitals are important providers of primary and ambulatory care to poor persons who often have little or no access to private physicians.

NAPH members average almost 106,000 bad debt and charity care outpatient and emergency room visits, representing about 50 percent of all visits at these facilities. These uncompensated care visits are a primary reason that public hospitals average 1.5–3 times the number of visits to all hospitals in the nation's 100 largest cities. In some states, the proportion is far higher. Grady Memorial Hospital, for example, in 1981 provided 28 percent of all the outpatient visits to hospitals in the entire state of Georgia. The costs for this care are high—almost $11 million per NAPH institution.

Public hospitals also experience a far higher average level of admissions through the emergency room (over 41 percent for public hospitals in metropolitan areas, as compared with 25 to 33 percent for large city hospitals in general).

In addition to the great burden of outpatient/emergency room charity care currently borne by public facilities in our nation's metropolitan areas, the Urban Institute study finds that high volume providers of care to the poor outside the 100 largest cities are reducing emergency room and outpatient hours or staff at a rate approaching twice that of low volume providers suggesting that metropolitan public hospitals may have to care for these patients as well.

5. Public hospitals in metropolitan areas also provide specialized tertiary care, public health, and other unique services.

These services are often too costly or too "unreimbursable" for most private hospitals to maintain. They include burn units—trauma centers—emergency alcoholism, drug abuse, and child abuse centers—neonatal intensive care—poison control units—to name just a few. New Urban Institute data shows that public hospitals with operating deficits in the Nation's largest cities were nearly four times more likely to have a burn unit, and about twice as likely to have neonatal, pediatric and psychiatric intensive care units than similarly located private hospitals.

6. Public hospitals in metropolitan areas are also important and valuable resources for medical education.

NAPH members devote significant resources to the training of physicians and other health professionals, and particularly in primary care specialties. Nationally, NAPH members average a 0.29 resident-to-bed ratio, with an average of 170 house staff per hospital. We estimate that NAPH member hospitals alone train some 6,600 house staff per year, or about 10 percent of all house staff trained nationwide. The importance of these training programs to the areas of greatest national need is underscored by recent data from our members in California, which indicate that over half of public house staff in that state are being trained in family practice, general practice, pediatrics, ob-gyn, and internal medicine.

7. Public hospitals have managed their resources efficiently. But their very mission often causes them to operate at a loss.

A recent study by Alan Sager, of Brandeis University, indicates that public hospitals have experienced the largest decrease in length of stay, and the only increase in occupancy rate, among all classes of hospitals in the Nation's 52 largest cities. Moreover, public hospitals have decreased their total number of beds between 1970 and

1980—by over 22 percent—in those cities. In addition, most public hospitals are already managed and budgeted prospectively each year, with full, independent review by state and local governmental entities.

Despite these efficiencies, the medical education, "safety net" and public service mission of metropolitan area public hospitals (in addition to their locations) often causes them to operate at a loss year after year.

Urban Institute data can also be cited to summarize this perilious situation (see Table III). They have compared hospitals in the Nation's 100 largest metropolitan areas by their costs, revenue and financial status (as measured by their operating and total margins). All hospitals in metropolitan areas generally averaged nearly $10 or $30 in surplus revenues per inpatient day, depending on whether they were characterized as "high volume" or "low volume" providers of care to the poor. Public hospitals as a separate group experienced a loss of almost $18 per inpatient day. In addition, their rate of revenue per inpatient day was $12-20 lower than the overall average for high volume and low volume hospitals (which includes all of the public hospitals in the sample). This situation is further exacerbated by the fact that the level of inpatient Medicaid payments per recipient for public hospitals—$1521—is $230 less than average revenues per patient for all high volume providers (again, including public hospitals).

TABLE III.—SELECTED FINANCIAL CHARACTERISTICS OF HIGH AND LOW VOLUME PROVIDERS OF CARE TO THE POOR IN THE NATION'S 100 LARGEST CITIES AND PUBLIC HOSPITALS IN THE 100 LARGEST CITIES—URBAN INSTITUTE SAMPLE

	Low volume[1]	High volume[1]	Public hospitals
Cost per inpatient day	$235.14	$277.05	293.93
Revenue per inpatient day	264.02	286.93	274.95
Cost per outpatient visit	62.93	63.00	69.18
Revenue per outpatient visit	70.17	50.95	40.20
Charity care and bad debt as a percent of charges	2.87	10.90	21
Surplus per inpatient day	28.89	9.88	−17.68
Surplus per outpatient visit	7.24	−12.05	−28.40
Operating margin	3.4	−2.6	−.15
Total margin	4.67	1.08	−1

[1] "High volume" providers are all hospitals with at least 13.54 percent of gross charges devoted to Medicaid, bad debt and charity care, while "low volume" providers are those which devoted 7.54% of their charges to those categories.

Source: NAPH analysis of AHA/Urban Institute Data.

The Urban Institute study has also revealed, from 1982 data, that almost 50% of large city public hospitals in the 100 largest cities showed a total margin deficit, compared to only 20% of the not-for-profits. Of those hospitals with a total margin deficit, the deficit for large city public hospitals averaged almost five times higher than large city not-for-profits. Charity care and bad debt as a percent of charges is also about four times higher in deficit public hospitals than deficit not-for-profits (See Table IV).

Among hospitals in the nation's 100 largest cities defined as providing a "high volume" of care to the poor (greater than 13% combined Medicaid, bad debt and charity care), 32 public hospitals and 72 private hospitals reported operating deficits, averaging 14.75% for the public hospitals and 3.42% for the private institutions. Public hospitals in this category averaged lower Medicare days, but significantly higher Medicaid days and bad debt/charity care than "high volume" private hospitals, as follows:

TABLE IV.—OPERATING DEFICIT OF HOSPITALS SERVING THE POOR

	High volume public hospitals (n = 32)	High volume private hospitals (n = 72)
Beds (average)	360	326
Percent Medicare days	30.89	42.58
Percent Medicaid days	25.39	19.92
Charity care/Bad debt as percent of charges	20.29	5.38
Total percent margin	−14.75	−3.42

Finally, public hospital costs per inpatient day were also $17-$59 higher than high and low volume hospitals in general.

Public hospital losses per outpatient visit were well over twice the rate of losses experienced by high volume providers in general, while low volume providers actually experienced a revenue surplus from outpatient visits.

Charity care and bad debt as a percent of charges averaged 21 percent for large city public hospitals, almost twice the rate of the average for high volume providers in general. Finally, public hospitals are the only group to show a negative operating margin and a negative total margin—characteristics indicative of financially stressed facilities.

8. In summary.

Caring for the poor in our nation exacts a high price from our public hospitals—higher costs, lower compensation and a stressed financial condition. And all of these factors are likely to have a severe impact on the ability of public hospitals to attract sufficient capital to enable them to fill this vital role.

III. UNCOMPENSATED CARE IN GEORGIA, AND THE SITUATION OF GRADY MEMORIAL HOSPITAL

A. The situation in Georgia

NAPH recently completed a report for the Georgia Hospital Association describing the State's current indigent care situation and recommending options for improving financing and service delivery to this population. Among the most important (and suggestive of the situation in several other states) findings were the following:

Medicaid coverage in Georgia is available to less than half of all persons with low incomes below the poverty line (46 percent), leaving one-half million of the state's neediest citizens uncovered by health insurance. (Very few such individuals are eligible for Medicare or private insurance.) Moreover, we estimate that there are also a large number of individuals with incomes only slightly above the poverty line, who are likely to require "uncompensated care" if they experience a major illness or need hospitalization.

There are 167 hospitals in Georgia, with 31,000 beds. These hospitals in the aggregate provided $231,000,000 and bad debt) in 1982, or 7.9 percent of their gross revenues on average. This amounted to $7,368 per bed in that year.

Only seven major tertiary teaching hospitals, located in Goorgia's SMSAs, provided $102,000,000 in free care, or 44 percent of all free care provided in the state in 1982. These hospitals have just 13.2 percent of all beds in the state, but accounted for $17,000 more per bed than the statewide average in free care. Between 8 and 36 percent of total revenues of such hospitals were devoted to free care. Just one of these hospitals—Atlanta's Grady Memorial Hospital—accounted for 17.8 percent of the state's total free care, or $46,000,000 in 1982. This care was supported almost entirely from county appropriations (42.2 million), but these appropriations fell $3.4 million short of meeting the total need in this one hospital alone.

It has been estimated that between 65 and 75 percent of the free care at this state's major tertiary/teaching hospitals involves inpatient costs, 13 to 24 percent are outpatient department costs for this care, and 9 percent to 20 percent are emergency room bad debt and charity care costs. Services most needed by these indigent patients included maternity, neonatal and pediatric care, medical and sugical care, and emergency care for accidents and other traumas.

B. The situation of Grady Memorial Hospital

Grady Memorial Hospital is the largest general hospital in Georgia. Its budget exceeds $115 million (as of 1983), with dependence on city/county appropriations and Medicaid for the bulk of its support. These sources alone ($41.7 million and $25.2 million, respectively) account for about 60 percent of all revenues for this hospital.

In 1984, there were 46,496 admissions to the hospital and over 800,000 outpatient visits. Over 260,000 of the outpatient visits were made to the hospital's five emergency clinics (surgical, medical, pediatric, obstetric, and phychiatry). In addition to the regular hospital operations, Grady also operates special clinics and centers including a Burn Center, a High Risk New-Born Nursery, a Maternal High Risk Program, a Diabetic Day-Care Center, a Hospic Program, and a State Poison Control Center.

Delivery of quality, state-of-the-art care is made possible by the 4,000 highly trained professionals that comprise the staff at Grady. As indicative of both a critical part of the staff and the major role this institution plays in medical education, Grady provides training to over 300 residents per year. This is accomplished in conjunction with the Emory University School of Medicine, which has provided supervision and direction of the patient professional care programs at the hospital for over 30 years. In all, 25 percent of the physicians currently practicing in Georgia were trained at Grady.

The extent of services provided to its community, as well as residents throughout the State, illustrates the importance of Grady as a provider of care to all. Fifty-five percent of all non-emergency outpatient visits were made to this one hospital; Grady provided 12 percent of all emergency room visits to all hospital emergency clinics in Georgia. With regard to care for the poor, according to a recent GAO study, 53 percent of all hospital Medicaid admissions in the two-county greater Atlanta area were made to this one hospital. The next highest hospital represented 9 percent of the area's Medicaid inpatient admissions.

I believe the special place and role of my hospital in the community was captured recently in an interview with Manuel Maloof, the Dekalb County Commission Chairman: "If you were to tear down every building in our metropolitan area, the last building you should tear down is Grady Memorial Hospital."

As a result of our present role in the region's health system, we feel the suggested changes in the President's budget will be a disaster to the hospitals that serve a disproportionate number of low income people.

For example, if the legislation is passed to maintain prospective payment rates for hospitals at fiscal 1985 levels, by making certain assumptions, we have determined that we would lose $900,000. If you freeze the direct medical education at 1984 levels, we would lose approximately $125,000. If you reduced the indirect medical education factor from 11.59 to 5.795 and maintain the rates at fiscal 1985 levels, we will lose approximately $4 million. As you can see, the changes will cost this one hospital, which serves so many poor people, approximately $5 million per year. We have no place to turn except to the local taxpayer. It seems that we are simply shifting from a large tax base to a very small tax base which will seriously hamper our ability to render the necessary care to poor people.

In addition, the State of Georgia, under the leadership of Governor Harris, was planning to expand its currently very limited Medicaid program this year. As you know, our state is behind many of the richer states in its Medicaid Program and, therefore, does not have as many Federal dollars involved in providing health care to the poor as many other states. It is my understanding that Georgia will defer any expansion of the program until it determines how it will be affected by the President's budget. I'm sure if the federal Medicaid program does not permit Georgia to expand so that Georgia can try to catch up with some of its sister states, the Legislature will not permit the expansion.

As we attempt to determine how much funding we will have in a given year, it is very difficult to plan, because of the changes that come so rapidly. You will remember that we had TEFRA for one or two years. As we were getting adjusted to that, the DRGs appeared, and as we are adjusting to this new program, freezes and reductions are being proposed. As a result, it is virtually impossible to plan in a facility such as Grady, which serves such as disproportionate number of low income people. This hospital receives about 40 percent of its income from the taxpayers in Fulton and Dekalb Counties. In addition, about 20 percent comes from Medicaid and about 20 percent from Medicare. Therefore, if that 40 percent is reduced, we have no other source but the local taxapayer, who is already paying an enormous amount of their property taxes for the health care of the poor.

IV. IMPACT ON PUBLIC HOSPITALS OF THE PPS SYSTEM—AND THE ADMINISTRATION'S FAILURE TO IMPLEMENT A "DISPROPORTIONATE SHARE" ADJUSTMENT

A. Impact of the PPS system

In this last part of my testimony, I would like briefly to summarize the impact on the nation's public hospitals of the Medicare PPS system, in order to indicate the extent to which we believe the financial situation of our present health "safety net" is likely to deteriorate in the future as a result of present trends, to discuss the need for a "disproportionate share" hospital adjustment, and to lay the groundwork for your consideration of possible future reforms.

At the time Congress enacted the new Medicare prospective payment system, NAPH expressed serious concern that the new system would not adequately account for the special characteristics of public hospitals and their patients. In particular, we were concerned that Medicare patients in public hospitals were likely to be sicker, with more complications, than their counterparts in private hospitals, and that the special costs associated with treating low income patients in general would not be accounted for in a single-price prospective system. As a result, the Congress included in that legislation an amendment which required the Secretary of HHS to determine the extent to which it would be necessary to provide exceptions, adjustments or some other form of relief for those hospitals (public and private) that serve a "significantly disproportionate number of low income and Medicare patients."

This amendment was virtually identical to a similar requirement adopted by Congress in TEFRA; and like the TEFRA provision, this new amendment has been virtually ignored by the Administration. Not only has the Administration failed to authorize specific adjustments or exceptions for such hospitals, the Health Care Financing Administration has failed even to develop criteria for defining "disproportionate share", or for identifying hospitals meeting such criteria, so that their costs and needs could be individually and accurately assessed. Subsequently, the Congress acted last year, in the Deficit Reduction Act of 1984, to order the Secretary to report back by December 31st on the identity and location of such hospitals. The Administration has also ignored this most recent Congressional mandate.

The federal courts have now also expressed serious concern in this area. In particular, the Federal District Court for the Northern District of California, in *Redbud Hospital District* v. *Heckler*, has ordered the Secretary (among other things) to implement "regulations or policies" with regard to the special needs of "disproportionate share" hospitals. NAPH, together with the Catholic Health Association, the California Association of Public Hospitals and four labor unions have now intervened in this suit to enforce the court's order.

Meanwhile, however, we have begun to accumulate a significant amount of data indicating that this Congressional and judicial concern has been well placed, and that public and other "disproportionate share" hospitals are indeed likely to be disadvantaged under the new PPS system.

Our preliminary analysis of this new data indicates the clear need for some form of exception or adjustment for such hospitals.

We have, for example, begun to develop data indicating that the case mix of hospitals serving disproportionate numbers of low income patients is substantially different from the national average, with more outliers, and a greater proportion of cases in DRGs with considerably greater internal uncertainty and variation.

When we first testified before this Committee on the PPS system, we submitted preliminary data gathered by researchers, such as Jeffrey Merrill and Michael Schwartz, which included findings such as the following:

Public hospital septicimia patients are 2½ time more likely to have tuberculosis than those in private hospitals.

Substantially more public hospital diabetes patients have complications than in private hospitals.

Of all public hospital discharges 3.5 to 7.1 percent are "outliers", with longer than average length of stay, as compared with 1.7 to 3.9 percent in nonpublic hospitals.

Of "outlier" discharges 90 percent with cerebro-circulatory admissions come into public hospitals through the Emergency Room.

Public hospitals treat significantly more patients with infectious diseases, mental disorders, and ill-defined conditions and injuries (e.g., accidents, violence) than private hospitals.

Subsequent analysis has underscored those findings. For example, we asked Systemetrics, Inc., to study Bellevue Hospital patients, using their "disease staging" methodiology. Their preliminary analysis was that over 30 percent of Bellevue's patients were in more complicated stages, requiring more resources, as opposed to just 24 percent of patients with similar diagnoses in ten private urban teaching hospitals.

D.C. General Hospital is an NAPH member that has been under the new PPS system since its inception, due to the questionable honor of an October 1 fiscal year. Their preliminary analysis, set out in Table V, indicates a substantially greater prevalence of Medicare DRGs more likely to be associated with low income patients—and with multiple complications. The second most prevalent D.C. General Medicare diagnosis, for example, has been DRG 296 (Nutritional and Miscellaneous Metabolic Disorder), and the fifth most prevalent is DRG 294 (Diabetes). Together, these two diagnoses have accounted for 7.1 percent of D.C. General's Medicare admissions. In addition, 4.4 percent of D.C. General's admissions were in the "unrelated" and "ungroupable" DRGs 468 and 470. Noticeably absent from D.C. General's Medicare admissions were such national "top 10" DRGs as #243 ("medical back problems"). We are now seeking to replicate this analysis for NAPH members nationally.

TABLE V.—D.C GENERAL HOSPITAL COMPARISON OF 10 MOST FREQUENT MEDICARE DRG'S: HOSPITAL SPECIFIC VERSUS NATIONAL

Rank	National			D.C. General Hospital		
	DRG No.	Description	Percent of national discharges	DRG. No.	Description	Percent of DCGH discharges
1.	127	Heart failure shock	4.9	127	Heart failure plus shock	5.8
2.	039	Lens procedure	4.0	[1] 296	Nutritional and Miscellaneous metabolic disorder.	4.4
3.	[1] 182	Esophagus, gastroenteritis plus miscellaneous digestive disorders.	3.7	014	Specific cerebrovascular disorders	3.2
4.	089	Simple pneumonia and pleurisy	3.3	[1] 468	Unrelated or procedure	2.7
5.	014	Specific cerebrovascular disorders	3.1	[1] 294	Diabetes, age 36	2.7
6.	[1] 140	Angina pectoris	2.9	039	Lens procedures	2.2
7.	[1] 088	Chronic obstructive pulmonary disease.	2.1	138	Cardiac arrhythmia plus disorders	1.9
8.	138	Cardiac arrhythmia	2.0	[1] 470	Ungroupable	1.7
9.	[1] 243	Medical back problems	2.0	089	Simple pneumonia and pleurisy	1.7
10.	[1] 096	Bronchitis and asthma	1.9	[1] 087	Pulmonary edema plus respiratory failure.	1.6
			29.9			27.9

[1] Connotes DRG which does not appear on both lists.

We have recently surveyed NAPH members nationally regarding the general impact on revenues and costs of both TEFRA and the new PPS system. With 27 respondents to date, it seems clear that the concept of "budget neutrality" is simply not working for large public hospitals. Following the imposition of the TEFRA payment methodology, it appears that average total Medicare revenues for respondents increased by $1.93 million, while average costs increased by $1.01 million. In the first year of PPS, however, average Medicare revenues have decreased for public hospitals by $2.46 million, while average Medicare costs have increased by $1.1 million. Moreover, it appears that the patient care revenue figures for both periods may in fact be overstated, due to the inclusion by some hospitals of their teaching cost adjustments in these figures. Even from this data, it appears that Medicare is no longer paying public hospitals at least some portion of the extra costs incurred to meet the special needs of low income patients.

B. "Disproportionate share hospital" studies

1. HCFA internal analysis.

It is our present understanding that HCFA has itself determined in an unreleased study that they are able approximately to measure a hospital's portion of Medicaid, Hill-Burton, Title V, other "government" patients, and a category of patients reported as "self pay", a surrogate for low income patients.

HCFA's effort to quantify and measure the impact of these factors, using the Med Par data base and the Office of Civil Rights survey, appears to bear out NAPH's own analysis, e.g., that public hospitals in cities of 1 million or more experienced a total of 41 percent of their patients, on average, in these categories in 1981, as compared with just 17 percent for non-public hospitals. "Self pay", while not specifically requiring medical indigency, appears to be a category highly correlative with low income, as most "self pay" patients are likely to be uninsured and most uninsured patients are likely to be low-income.

HCFA's preliminary 1984 internal analysis shows that public hospitals in large cities had 16.8 percent "self pay" patients in 1981, as compared with 4.9 percent in non-public hospitals in those cities. HCFA also found that such hospitals had higher

Medicare costs per case than other hospitals in the same cities, by a significant factor.

HCFA staff then also performed a regression analysis of this "low income patient" factor, which corrected for the impact on Medicare costs of wage differentials, case mix index, proportion of housestaff per bed and bed size. They found a statistically significant impact, apart from these other factors, an increase in the proportion of low income patients on Medicare costs.

Specifically, in 1980, for every 1-percent increase in the HCFA "proverty factor", Medicare costs per case increased by .09 percent (.059 in 1981).

2. District of Columbia Hospital Association report.

Our expectation with regard to HCFA's internal analysis has been underscored significantly by the findings in a new study released late last year by the District of Columbia Hospital Association. DCHA surveyed 257 hospitals in five metropolitan areas (Chicago, Cleveland, Minneapolis-St. Paul, Philadelphia, and Washington, D.C.) and determined that the overall costs for patient care in inner city hospitals with higher low income case load are significantly higher than in suburban hospitals. Specifically, DCHA concluded that a facility with 20 percent Medicaid patient days could be expected to have a Medicare Medicaid case load. Furthermore, DCHA found a direct correlation between higher costs and care for low income patients even after correcting for the impact of a teaching program and such other factors as bed size, case mix index, and wage index.

3. American Hospital Association research.

The AHA, in November, 1984 report, analyzed the impact on over 2,000 hospitals of the relative proportion of charity care, bad debts and Medicaid, as a percentage of gross revenues. The AHA study confirmed that there were additional costs associated with serving large numbers of low income patients. AHA estimated specifically that for every 1-percent increase in the proportion of Medicaid, bad debt and charity care, a Hospital would experience a 0.4 to 0.5 percent increase in Medicare costs per case.

Previously, in 1983, in preparation for Senate debate on House-passed "health care for the unemployed" legislation, AHA was able to provide for NAPH a specific determination of the extent to which the nation's hospitals experienced a high proportion of charity care and bad debt as a percent of gross patient revenue. Using 1981 data, the AHA found that just 1.8 percent of the hospitals in the nation (or 104 hospitals) had 15 percent or more charity care and bad debt, while just 5.7 percent of all hospitals, (or 337 hospitals), had 10 percent or more charity care and bad debt.

4. Congressional Budget Office study.

CBO has undertaken a study to estimate the impact of a fully implemented prospective payment system on hospitals in general, and disproportionate share hospitals in particular. Preliminary CBO analysis based projections on the relative proportion of Medicaid inpatient days alone. CBO determined that, nationally, hospitals experienced an average of 11 percent Medicaid inpatient days. CBO therefore arbitrarily designated hospitals with more than 20 percent of their inpatient days attributable to Medicaid patients as "significantly disproportionate." CBO found that on average, such hospitals would experience a deficit of 3 percent under a fully implemented PPS system, and that within almost every hospital group examined (by bed size, urban or rural location, region, teaching status, and ownership), surpluses would be diminished or deficits increased among disproportionate share facilities. Larger hospitals (300+beds) in urban areas appeared to be the most adversely effected.

CBO is currently examining the effect of non Medicaid indigent care on Medicare cost per case. Findings from a number of sources suggest that these results will also be positive and significant.

While CBO found that the teaching adjustments, at their current level, mitigate some of the adverse effects, they also determined that public hospitals with teaching programs would experience an average deficit of 5 percent if the teaching adjustment is cut in half, and such hospitals in the nation's largest metropolitan areas were estimated to experience an average deficit of 16 percent under those circumstances.

With regard to a specific correlation between "disproportionate share" and Medicare costs, CBO concluded that for each 10-percentage point increase in Medicaid inpatient days . . . a hospital's surplus (deficit) would decline (increase) by 2.5 percent.

C. Constructing an appropriate adjustment

In light of the studies outlined above, we believe it can no longer be contended by HCFA that a "disproportionate share adjustment" is unwarranted—a position clearly also supported by the Prospective Payment Assessment Commission in its recently submitted report.

It remains only to consider the most appropriate methodology for constructing such an adjustment—and if necessary, writing it directly into the statute.

While technical definitional problems may remain, we believe adequate data presently exists to calculate and construct an automatic adjustment based on the proportion of low income patients, with several possible ways of measuring that factor. We have previously provided information and recommendations to your staff with regard to such an adjustment, and we would be delighted to continue to work with you on this important matter.

We believe that it is essential for Congress to continue to insist on the implementation of the "disproportionate share" provision, in order to protect and preserve services which we believe are essential to the fiscal stability of our nation's health system. Your Committee should start by immediately insisting that HCFA meet its December 31st deadline for developing criteria for defining what constitutes a "disproportionate share" of low income patients and identifying hospitals meeting such criteria. However, we believe it may be necessary to go further than that, and actually write a specific adjustment into the statute.

D. Conclusion

The impact of other health system reforms on the future of "disproportionate share" hospitals

Finally, I would like to offer several comments on the cumulative impact on "disproportionate share hospitals" of a number of other health system trends. Other governmental health system reforms with the potential to assist public hospitals have been largely notable by the failure of Congress to enact them. Apart from a modest but welcome expansion of maternal and child health coverage in the 1984 amendments, Congress has thus far considered, but stopped short of enacting, efforts to provide health coverage for the unemployed, direct grants to public hospitals, and additional financing for programs serving illegal aliens. In each case, we have worked hard to achieve Committee approval, and in several cases approval by the full House, of these provisions, only to see them flounder for various reasons.

While the federal government has thus simply refused to assist public hospitals, "reforms" in the private sector promise to substantially damage our ability to provide services. As trends increase toward the development of PPOs and other alternative private insurer discounting arrangements, we are hit by a double edged sword. On the one hand, we are usually too costly, for reasons often beyond our control, to participate on an equal footing in such ventures ourselves. Therefore, we risk losing such private patients as we have. On the other, as these arrangements increase pressure on private hospitals, we will be forced to receive those less economically viable patients they are no longer willing to treat.

To be sure, a number of NAPH members are going to try to compete in this system—those whose physical plant, service\mix, fiscal situation and patient load permit. Some of us will form or join (or even start) PPOs or HMOs, and even try to develop such new entities for our Medicaid and indigent patient populations. But you must recognize that this will be an uphill struggle for many public hospitals, and if you also believe that we are important elements of the present health care system, then you must be prepared to assist us in this area as well.

The cost of maintaining quality and a state of preparedness in tertiary care for all persons, regardless of ability to pay, should be viewed as a legitimate cost to meet a vital community need, much like the premiums for a health insurance policy you hope you never have to use.

We should be innovative and step back from the current system enough to allow a little introspection. We should not lose sight of the dream of an appropriate level of health care access for everyone. This can only be achieved if providers and the government jointly accept the responsibility to make that access available in an efficient, effective and dignified manner.

Health care needs to be run like a business, but it is not "just business." Society expects more from us and that is one of the reasons that competition on an unlevel playing field will never yield equity nor will it improve access for the poor.

Today, America is returning rapidly to a two class system of health care—one composed of private providers competing for insured, generally health individuals and the other consisting primarily of the network of public (and a few private) hospitals serving the needs of the indigent and severely ill who have no access to mainstream medical care. All of this is being done in the name of cost reduction, competition and private entrepreneurial spirit.

In order for public hospitals to live in this new world, there must be an explicit recognition of these changes and recognition of the critical role of public hospitals. Measures must be taken to safeguard our survival and, therefore, access to health care for the nation's poor. In addition, we believe the sweeping changes in Medicare reimbursement—from DRGs to the extraction of a much higher out-of-pocket cost from the beneficiary—will increasingly require us to serve the elderly as well, as they are increasingly "welfarized" by changes in the Social Security and Medicare systems. My colleagues in the public hospital sector are absolutely convinced that this will occur—particularly with those Medicare patients likely to be "outliers" in private hospitals, and those who will no longer be able to afford substantially increased premiums, copayments and deductibles. As the private sector makes its business decisions only we, the public hospitals, will, to the extent that we can survive, remain to care for America's most vulnerable populations.

Chairman STARK. Thank you very much.

There is a chance for you, Mr. Gage, and Jack Owen and myself to solve this problem. I understand that the AHA has some revenue data which is guarded. I am wondering if we did one of two things.

We are not getting the best service out of HHS, and it is understandably difficult for them to do it.

Jack, if we agreed to take it in closed session, would that help assuage the fears of your members about this—it seems to me the data is there. What Mr. Gage would like to achieve, which many members of this committee would like to achieve, is within our grasp.

We don't have the information to build a reasonable list. Once that is done, the administration would have to immediately respond because if they didn't, we would go ahead and run with our list.

Is there some way, either after this hearing or in the next week or two, that you could counsel with us as to how we might bring that data to this committee and proceed?

Mr. OWEN. I would be happy to, Mr. Chairman. We do have the data for 658 hospitals, by congressional district and what have you. When we collect this data, we have a commitment to the hospitals that we will not release it without them agreeing to the release.

Chairman STARK. I understand that. Secret testimony, and second, to ask you to sanitize the data. I would be perfectly willing to write legislation that deals with qualifications, as long as we can see the type of revenue structure that we are trying to identify. It is probably easier than naming the hospital, but we have to have some guidelines, and without the HHS report or your data, we are whistling in the dark.

Mr. OWEN. On Friday, I sent a letter to each of the 658 hospitals, asking for permission to make this available to the committee. I knew of the concerns of these hospitals. I would guess that by Wednesday of this week, we would have answers from a good many of them, and perhaps at that point, we could discuss the possibility of some kind of a closed session.

I would want to protect the hospitals, though.

Chairman STARK. I know I can speak certainly for myself, and I do this very reluctantly, but indicating—our ranking member, Mr. Gradison, has a strong interest in this case information, and we would like to proceed with seeing those payments adjusted. I assure you that our staff and the Chair will work with you in whatever way we can.

And if we can't get it out of HHS, we will have to go ahead and do it ourselves, because I think it is essential.

If you have reliable data on which we can base a program on, please share it with us.

Dr. Mongan, would you endorse the Stark proposal for paying for the cost of medical education? It is really quite simple. I just have a hunch, that when dealing with teaching hospitals, we are too subject to being flimflammed by smart cost accountants who can run circles around me and my staff, in terms of what it costs.

If we were able to determine the cost of medical education, why should we not go ahead and fund it for those who choose the whole thing. The cost of attending the medical department of a university, whatever that might be, 20, 30, $40,000 a year, and then once the physician has graduated and is in practice, apply to that physician an excise tax to his or her fees for the rest of their lives.

Then, the very successful ones would pay more, which is very progressive, and in the best interests of free enterprise, and adjust those fees, and waive it when we have a need for family practice, or pediatrics. Then encourage people to move into family medicine, waive the excise tax, and be done with it once and for all.

Take a little bit off the top, as a person goes on through life? Would your group endorse that kind of a proposal?

Dr. MONGAN. Jack only needs 657 approvals to release his data, because you can have ours. With respect to the proposal, there are some of the Nation's medical school deans who could address the medical costs and tuitions, and whether that, in fact, is a fair way to assess that burden.

Physicians are coming out of long residency training with a much heavier debt burden than they used to in the past. It is unusual for me to be in the position of defending doctors and doctors' incomes, but I do worry about a proposal which would load a heavier debt on a number of young physicians who are coming out already in debt.

Chairman STARK. Quite the contrary. This wouldn't have to be 1 percent of this gross fees, a very modest amount, that would help the younger physician who has to pay a third or a quarter of his gross to fund those things early on in their careers.

Dr. MONGAN. I am game to explore almost any proposal. The facet I would like to underscore that may be a bit problematic, in a public policy, since it is inequitable to put the indirect teaching costs onto the physicians, because that is a cost of patients being sick or who come to teaching hospitals in large part, and that gets to be a bit of a dicey proposition, and I would maybe distinguish the direct from the indirect costs in that kind of a proposal.

Chairman STARK. Mr. Gregg.

Mr. GREGG. Do you have statistics which also tells us what the bed utilization figures are for your various hospitals?

Mr. OWEN. Yes, we do. For 1984, just completed, it was 66.4 percent. We have it by individual hospital. They are published in our guide issue, but it is about 2 years behind when it is published.

Mr. GREGG. Are those figures trending down?

Mr. OWEN. Yes, they are.

Mr. GREGG. Significantly.

Mr. OWEN. They have dropped from 72 percent a year ago to 66. I am not a math major, but that is a drop of about 6 percent.

Mr. GREGG. Do you also have statistics which could tell us what percentage of hospital income now comes from offsite activity?

Mr. OWEN. You mean from outpatients or from other forms?

Mr. GREGG. Broken down between out-patient and having outreach clinics?

Mr. OWEN. No.

Mr. GREGG. Are you compiling any data as to how many hospitals and what percent of their activity is outreach or basically clinical?

Mr. OWEN. We don't have that information. We have outpatient and inpatient revenues, but whether a hospital counts, if it is operating a clinic downtown, it may not count that as strictly an outpatient clinic.

My answer would be probably, we don't have the data, other than for outpatient and inpatient.

Mr. GREGG. You would have no way of knowing whether there is a significant increase in that figure.

Mr. OWEN. A significant increase in outpatient utilization, yes. As inpatient admissions go down, the outpatients go up. Clinics, we can't answer that one. In my travels around the country, the inpatient-outpatient is happening.

Mr. GREGG. Is there any way we could get information like that?

Mr. OWEN. No, I would have to come back and answer that after I have talked to our statistical people, to see whether it is available.

Mr. GREGG. On the utilization side, are you able to give estimates, or do your numbers show general trends as to those types of hospitals which we are finding are fairly significantly underutilized?

Mr. OWEN. We have it by individual hospital. We are finding that utilization is dropping—there are empty beds. The problems occur in the more rural parts of the country, where the problems are larger than they are in the more metropolitan areas, because the hospitals are small, and as the decline occurs, it has a more dramatic effect.

Mr. GREGG. Dr. Mongan, would your group be willing to accept a lower percentage for the indirect teaching adjustment?

Dr. MONGAN. Mr. Gregg, we believe that an adjustment, a teaching adjustment is deserved. The original adjustment, 5.79 percent, which was subsequently doubled, was based on a flawed analysis and was too low.

Congress doubled it so the teaching hospitals would be treated equitably with other hospitals. We feel we now have better data and analysis which indicates the adjustment should be about 9 percent, and we believe that is the factor which ought to be paid.

Mr. GREGG. Thank you.

Chairman STARK. Mr. Pickle.

Mr. PICKLE. Let me ask you gentlemen a broad question.

Has the DRG program worked satisfactorily?

Mr. OWEN. It has worked the way we anticipated. It has made some great changes in the way medical care is delivered and how it is paid for. It has been effective in the first year because the price was fair.

It has been effective because hospitals went in there believing that a commitment had been made, that once the price was struck, it would move forward at a market basket plus 1 percent, which was cut to a quarter of a percent.

How it is going to work under a freeze and at the end of this year, after we didn't get market basket in this fiscal year we are in right now remains to be seen, but the principle of the DRG system is fairly sound and has worked effectively.

Mr. **Pickle.** That is the main thing, the principle of it. It is not all even phased in yet. In general, is it going in the right direction? Do you disagree with that?

Dr. **Mongan.** It depends on what you mean by work. Cost reimbursement was an atrocious way to pay hospitals. The move to a prospective rate as in the DRG system has worked in that it has given hospitals additional incentives to operate efficiently, et cetera.

I believe very strongly as that moves on to a national rate, it will not work, and we are in for very serious difficulties ahead.

I believe prospectively is important. I do not believe a single arbitrary national rate is important, and that can lead to squeezing some hospitals very, very hard and giving huge windfalls to other hospitals.

Mr. **Pickle.** We have received reports that by and large it has worked. The days for release are getting a little bit less, maybe 1 day at least, 2 perhaps too soon. Overall, we hear it is working now.

I want to ask you as a group, are you developing some way, once that patient is released from the hospital, to still have some way to take care of that patient?

In other words, do you refer these people to the home health services, is that a growing practice?

Dr. **Mongan.** Yes, sir; at our facility, we have done two very real things.

Mr. **Pickle.** Is that true?

Mr. **Owen.** Yes; there is a problem of transition for a sicker patient—we are running into some problems there, if there is not a good intermediate step.

Mr. **Pickle.** If you are referring them to a home health service, that is a growing practice, I take it?

Mr. **Owen.** Right.

Mr. **Pickle.** I have to assume that that is correct, and you would not disagree with that. Is it growing rapidly? That would depend on what you mean by rapidly. My figures show that it is, and with 100 percent reimbursement in time, it may be that what we have saved in the hospital we are going to add over here in the home health care service. Maybe we have to look at that approach again, and you can understand that.

Do you have or do your hospitals have their own home health care services?

Mr. **Owen.** Most do. Some don't.

Mr. **Pickle.** Most do. Where is the saving on this?

Mr. **Owen.** I am sorry?

Mr. PICKLE. Where is the saving on this?

Mr. OWEN. It is much less expensive to take care of a patient in his home than it is in an institution.

Mr. PICKLE. You say it is. In many cases, with complete reimbursement, I question whether that saving is going to be very material, and we may find that is the case, at least we must not let that develop, so that is a concern we have. You are saying to me in many cases, the hospitals have their own health care services, some working relationship?

Mr. OWEN. Their own and/or a relationship.

Mr. PICKLE. When you have a patient that must be moved from a hospital, do you find a satisfactory degree of cooperation from the skilled nursing home, the private home, do they take your patients out of the hospital?

You need to move them out of the hospital, you can't cure them there, would a private home take them in every instance?

Mr. OWEN. No. It depends on the section of the country.

Mr. PICKLE. You indicate to me that it is a problem getting private homes to take them?

Mr. OWEN. There are sections of our country in which there is a shortage of nursing home beds, and the hospital has been stuck with patients because they are too sick for home health care and there is no skilled nursing care available.

Mr. PICKLE. Give us a list of the sections of the country.

Mr. OWEN. I spent quite a few years in New Jersey before I came down here. There were 1,000 patients in the hospitals in New Jersey that couldn't be transferred, because there were no beds for them in nursing homes.

Mr. PICKLE. We have been told that in many cases the skilled nursing homes just don't want them.

Mr. OWEN. If you are a private pay patient, sometimes it helps.

Mr. PICKLE. What do you do with them?

Mr. OWEN. In most cases, the hospital eats the loss. That is part of the problem. You can't just put them out on the street.

Mr. PICKLE [presiding]. I thank the panel for your testimony. Mr. Stark had to step out, so we will continue with the next panel. We will be submitting questions to you for answers in writing.

Mr. OWEN. Thank you.

Mr. PICKLE. Now we will ask the Catholic Health Association, the American Protestant Health Association, and the Federation of American Hospitals, if you will come forward to the witness table.

I want to recognize Sister Sheila Lyne, president of the Mercy Hospital of Chicago, IL.

Sister LYNE. Thank you, Mr. Chairman.

Mr. PICKLE. Dr. Umbeck, you are at the table, and Michael Bromberg, our old friend and executive director of the Federation of American Hospitals.

Sister, you may proceed. Do you have a prepared statement?

Sister LYNE. Yes, I do.

Mr. PICKLE. Let me ask each of you—Mr. Stark had to leave early, but we would like to finish this panel and we will get all of your testimony on the record. Whether he will be able to come back, I don't know, but we will proceed.

STATEMENT OF SISTER SHEILA LYNE, PRESIDENT, MERCY HOSPITAL & MEDICAL CENTER, CHICAGO, IL, ON BEHALF OF THE CATHOLIC HEALTH ASSOCIATION OF THE UNITED STATES

Sister LYNE. Thank you very much for this opportunity.

I am Sister Sheila Lyne, president of the Mercy Hospital Center in Chicago. This afternoon I am testifying on behalf of the Catholic Health Association of the United States.

In the brief time I have before you, I will briefly describe Mercy Hospital and the Catholic Health Association, and provide a brief summary of our concerns with the Medicare prospective payment system and its future, our strong disagreement in opposition to the President's proposal to freeze the prospective payment rates and make cuts in Federal education, and suggest that the Federal budget process cannot continue to drive Medicare policy without doing substantial damage to the program and the health care of elderly Americans it was established to serve.

Mercy Hospital & Medical Center is a 526-bed facility in a poor section of Chicago. We employ more than 2,088 employees and about 300 physicians enjoy staff privileges at Mercy. A high percentage of Mercy's patients are Medicare, Medicaid and other low-income patients. Last year, these patients accounted for about 63 percent of Mercy's admissions.

The Catholic Health Association represents 288 long-term care institutions and 625 short-term acute care member hospitals. On average, the acute care institutions contain approximately 270 beds.

The Catholic Health Association strongly supports the Medicare prospective payment system. We want to work with the Congress and the administration and others to make the program a success in its current configuration, however, the system is not yet on the firmest ground. It is still relatively new and will require extensive fine tuning before it can be expected to fairly and equitably pay America's hospitals for the services they provide the Nations' elderly. Unfortunately, the President's fiscal year 1986 budget proposals address none of the program's systematic problems and, if implemented, will only serve to weaken it further.

The Federal Government currently uses four factors to adjust the PPS rates to account for cost per discharge differences between hospitals. Those factors are the area wage adjuster, the DRG weight, the indirect medical education adjustment and the annual update factor. From the beginning of the program, the accuracy and reliability of each of these factors has been called in to question.

For instance, the wage index has been criticized for not being sufficiently reflective of the differences in hospital labor costs from one locale to another. While the Department of Health and Human Services took early action to correct this situation, and has, in fact, submitted a report to Congress, implementation of the revised index is in doubt as its use would cause a substantial redistribution of Medicare dollars among regions of the country.

The DRG's themselves have also come under considerable criticism. A number of analysts have criticized the DRG's for not being sufficiently sensitive to the severity of illness. Others have criticized the DRG weights for overvaluing simple cases such as tonsillectomies and undervaluing more complex cases such as open heart surgery. There are a number of additional constructive criticisms that have been identified by the Prospective Payment Assessment Commission and have been recommended by ProPAC for further study.

The medical education adjustments have also been called into question. During the 1983 debate over prospective payment, Congress and the administration doubled the indirect teaching adjustment. The teaching adjustment was doubled to account for factors that are believed to make teaching hospitals more costly than nonteaching hospitals. At the time, it was speculated that much of these costs were associated with sicker patients, more costly technology, the cost of residents and higher indigent patient loads.

It is important to emphasize here that while no more is known today about what causes teaching hospitals to be more expensive than their nonteaching counterparts, the Reagan administration has nevertheless proposed that the teaching adjustment be reduced by half; and it has made this recommendation in the absence of any research-based justification for doing so.

The hospital market basket is supposed to measure the annual increase in costs of the goods and services hospitals must buy in order to deliver patient care. Shortly after the Prospective Payment Assessment Commission convened, it questioned the accuracy of the market basket. As part of its report to Congress, ProPAC has recommended further study of the market basket.

It should be obvious that much more work needs to be done with respect to improving the accuracy and reliability of the PPS adjustment factors before most providers will feel confident that the program treats them fairly and equitably. Should PPS lose provider confidence and, therefore support, the program might well collapse.

The President's proposal to freeze the PPS rates, rather than making a necessary contribution to the long-term stability of the PPS program, only serves to weaken it. Furthermore, the proposed freeze completely ignores the better than expected progress America's hospitals have been making over the past few years in terms of reducing Medicare expenditures. Medicare projected that under prospective payment, it would pay $42 billion for hospital services in fiscal year 1984; however, actual expenditures were $39 billion.

As the PPS Program was being debated, the Government conveyed the clear expectation that on an annual basis, the Secretary would examine the need to raise the PPS rates and in so doing would take into consideration the increase in input prices to hospitals as measured by the hospital market basket.

The administration contends that under a strict reading of the statute, the Secretary has the authority to freeze the PPS rates without congressional approval. Such an interpretation may be in keeping with the letter of the law, but it certainly shatters the spirit of the agreement between providers, Congress, and HCFA/HHS when prospective payment was enacted.

It also bodes ill for the future of PPS with respect to the kind of cooperation that must exist between providers and the Government in order to keep the program going.

The White House proposed freeze while unfair to all hospitals would be especially hard on those hospitals whose specific costs are higher than the national PPS prices. It should be noted here that Medicare may underpay such hospitals due to the deficiencies in the PPS adjustment factors noted above, as well as for other reasons not identified here. As PPS moves away from hospital specific rates and toward national rates, many of these hospitals will experience a substantial net reduction in PPS price per discharge from one year to the next rather than a net increase reflective of increases in the hospital market basket. For such hospitals, a freeze in the PPS rates is more than just unfair, it is wholly unreasonable.

For example, Mercy Hospital entered the Medicare Prospective Payment Program with a hospital specific cost per discharge of $4,963. During its first year under PPS, it is being reimbursed an average $4,629 per discharge, a drop of 6.7 percent from its original hospital cost per discharge.

If, on October 1, 1985, the Secretary decides to increase the national and regional PPS prices by a factor of market basket plus 0.25 percent, Medicare's average payment per discharge to Mercy in the hospital's second year under PPS would be $4,274 or a 7.7-percent drop in reimbursement per discharge over the first PPS year. If, on the other hand, the Secretary freezes the PPS rates at 1985 levels, Mercy would be paid an average of approximately $4,153, a drop of 10.3 percent over the previous PPS year.

In other words, a freeze would make it necessary for Mercy Hospital to cut its expenses by an additional 3 percent in the hospital's 1986 fiscal year if it sought to bring its Medicare costs per discharge under the PPS price it would be paid by Medicare.

The impact that the proposed freeze would have on Mercy Hospital appears even harsher when examined from another perspective. Between July 1, 1984, and June 30, 1986, the Medicare Program is projecting the hospital market basket to increase by approximately 14.2 percent. Yet, during that same period of time, as it continues the transition to national PPS rates, Medicare expects Mercy Hospital to cut its costs by 13.9 percent below its 1984 starting point, a divergency from the Government-projected hospital market basket of 28.1 percent. To ask Mercy to cope with a freeze in PPS rates in addition to having to cope with the transition to national rates is unfair.

The proposed cuts could cause Mercy to lose $1.7 million in addition to losses suffered as a result of the freeze. Mercy has gone through several years of severe cost cutting. Some of the measures we have taken resulted in a change in the manner in which we do business with our suppliers. Other measures have included minimal or no annual salary increases and asking donations of a percentage of employee salaries and reducing our number of employees by attrition.

Faced with cuts on the order of the magnitude in the President's budget, we must look to closing or curtailing services. One of the services that will be a candidate for curtailment in our hospital will be our clinic that is subsidized at the level of $750,000 a year. This clinic, which was begun in 1919, currently serves 15,000 people with 70,000 patient visits a year. Approximately 20 percent of the people cannot afford to pay the fees, others are charged a nominal amount of $1 a visit.

For most of these patients, this clinic serves as their primary care physician.

Therefore, the Catholic Health Association must oppose the proposed freeze in the PPS rates, must oppose a freeze in the direct medical education costs must oppose elimination of the doubling of the indirect teaching adjustment, and must oppose progress to the national average rate.

This year it is more obvious than in past years that Medicare policy is being driven primarily by budget considerations and not by what might be best for the health care needs of America's elderly. Faced with a fiscal year 1986 deficit of approximately $250 billion, the administration is seeking a $50 billion deficit reduction package, $4.2 billion of which is to come from Medicare.

But even if the Government succeeds in reducing next year's deficit by $50 billion, the Nation will continue to experience a vista of large and substantial deficits. Are we to expect that under such conditions this administration and possibly succeeding administrations will continue to seek annual Medicare cuts in the $4.2 billion range or larger?

Neither Medicare nor Mercy Hospital and other hospitals like it can continue to absorb cuts of this order of magnitude and expect to survive.

There has to be a limit somewhere on the extent to which the budget can continue to drive Medicare policy before irreparable harm is done to the program and the health of the elderly people it was established to serve.

Thank you.

Mr. **Pickle**. Thank you very much for a very good statement, Sister.

Dr. Umbeck.

STATEMENT OF PAUL F. UMBECK, D.D., IMMEDIATE PAST CHAIRMAN, AMERICAN PROTESTANT HEALTH ASSOCIATION

Dr. **Umbeck**. Mr. Chairman and members of the subcommittee, I am Paul Umbeck. I am the immediate past chairman of the American Protestant Health Association and the immediate past chairman of the Evangelical Health Systems of Chicago.

The American Protestant Health Association appreciates this opportunity to present its views on the critical issues raised by the administration's proposed fiscal year 1986 Medicare budget. We commend the subcommittee for holding hearings to examine this important issue in depth. We believe the administration's budget proposal is a breach of faith with the hospital community and will result in hospital staff reductions, thereby eroding the quality of care, reducing funds available for charity care and exacerbating a tendency toward a two-tier health care system.

I think, Mr. Chairman, you can appreciate the fact that a breach of faith implies it is extremely difficult to do long-range strategic planning in hospitals. We believe, obviously, that such planning is important for institutions such as ours and for those we represent within the American Protestant Health Association. When political issues become prevalant each year and change the game, it is extremely difficult for us to know now to operate.

Historically, the churches cannot accept the two-tiered health system. If we are to approach the fact, philosophically and logically, that every man is created equal, then each is entitled to the same kind of care. Historically, the American Protestant Health Association's hospitals are committed to charity care, to educational programs particularly when they are serving the intensely ill and those who are indigent.

Accordingly, the APHA is opposed to the administration's budget which would arbitrarily slash funding for the Medicare and Medicaid Programs. Under the proposed budget, the administration would bypass the Congress and by administrative fiat hold DRG rates at the fiscal year 1985 level. The Social Security Amendments of 1983, Public Law 98-21, require ProPAC to advise the Secretary on increases in PPS. ProPAC recently recommended that hospital payments be allowed to rise by 1 percent to 3 percent, which would result in a $600 million saving in fiscal year 1986.

While it is true that the administration has the authority to set PPS rates, such authority is not unfettered, and the rejection of the recommendations of ProPAC, in advance, could be construed as arbitrary and capricious action. The length of stay for Medicare patients has been significantly reduced by 20 percent, as I think we have demonstrated, since implementation of PPS and admissions are down for 1984 by over 4 percent from 1983.

Hospitals have responded to the Medicare reductions by implementing programs that have reduced Medicare costs increases by 13 percent while continuing to provide high quality care. The administration again is seeking to reduce the DRG rates in prices set for fiscal year 1986. The total package reduction of rates, and the continuation of the PPS transition period in 1986, will result in many hospitals receiving less in 1986 than they received in 1985.

This, certainly, is not a freeze. It is a regression. Freeze implies at least maintaining the status quo. We do not believe this to be a fact under the proposed budget. The proposed budget would freeze payment for direct medical education and cut by a half the indirect teaching adjustment. We do not object to fine-tuning of the indirect adjustment, but there is just no data to support cutting it in half.

With regard to the direct medical education, the administration proposes to reduce the direct payment cost passthrough to what it was in fiscal year 1984, the administration's proposal is indefinite, and is not limited to a 1-year period of time. We find difficulty with that fact. Moreover, the budget proposal must not be viewed in isolation. The administration has failed to implement the adjustment for those hospitals which serve a disproportionate share of low income or Medicare beneficiaries. The administration has failed to complete an indepth study of the case mix index as promised in August 1984 to determine whether hospitals are treating sicker patients under PPS.

The administration has yet to complete this study and development of a severity index to determine whether the resources which are used to treat a Medicare patient within a particular DRG necessitate adjustments. The administration has yet to deliver to the

Congress a proposed capital payment plan for Medicare. It has only recently delivered to the Congress a revised area wage index.

Medicaid, the health insurance for the needy, also is slated for significant reduction by the proposed budget which would cut 1 billion in payments to States under that program. Increasing indigent care caseload is very prevalent, particularly in our area. Increasing financial hardship to hospitals which continue to provide indigent care will follow. The hospital community is expected to make a disproportionate sacrifice and bear a disproportionate burden in reducing the Federal deficit.

Hospitals, including APHA, do not object to contributing their fair share, but the Federal deficit program should include all sectors of the economy and of the Federal Government. This is not a policy year for Medicare, but merely a budget year. The administration's proposed budget would, if not revised by this committee, implement a new policy for Medicare without the benefit of public debate. There is just no data for such a rush to action because even the most pessimistic estimate of the Medicare trustees does not contemplate depletion of the hospital insurance trust fund until 1992.

These severe budget cuts jeopardize the ability of hospitals to continue to provide the highest quality of care and access to such care to the 27 million elderly, 3 million disabled, and the 22 million indigent patients. APHA wishes to express that it will continue to work with Congress and the administration to devise a fair health care budget which will serve to reduce the deficit without jeopardizing the ability and quality of care to Medicare and Medicaid patients.

Please let me diverge from the text and state some of the things that are happening at the Evangelical Health Systems. We are a 1,645-bed system composed of five hospitals in the Chicago metropolitan area. We also have 387 beds of skilled nursing and long-term care. We have 6,500 employees. We have 1,000 physicians. We have 145 residents.

At the present time, we are doing charity in excess of $5.5 million. If the DRG's are frozen, it will mean a $366,000 loss to us in 1986. The indirect educational adjustment loss will amount to $4,542,000 and the direct educational loss will amount to $687,000 or a total loss in 1986 of $5,595,000 to our organization as a result of the administrations' Medicare budget for fiscal year 1986. This, we think, is significant because it exceeds the amount of charity which we are currently doing.

That is pure charity. That is not the losses that we incur through noncollectibles and certainly it is not including uncompensated care. We are willing as an organization to work in close association with you and, as you indicated earlier, we would be willing to work in closed session with the committee, endorsing the National Association of Public Hospitals and the AHA in trying to come to a workable solution.

Again, we appreciate the opportunity to testify and I will be pleased to answer any questions.

Mr. Pickle. Thank you, Dr. Umbeck.

[The prepared statement follows:]

STATEMENT OF PAUL F. UMBECK, D.D., ON BEHALF OF THE AMERICAN PROTESTANT HEALTH ASSOCIATION

Mr. Chairman and members of the subcommittee, my name is Paul F. Umbeck, D.D., and I am the immediate past chairman of the American Protestant Health Association [APHA] and immediate past chairman of Evangelical Health Systems of Chicago. The APHA appreciates this opportunity to present its views on the critical issues raised by the administration's proposed fiscal year 1986 Medicare budget. We commend the subcommittee for holding hearings to examine this important issue in depth.

The APHA is comprised of 300 institutions, agencies and nursing homes across the country, and the College of Chaplains, with 2,000 personal members in its division. The APHA has hospitals in 38 States, totaling 60,000 beds, and its hospitals are located in both rural communities and inner cities. Although the APHA hospitals are church-related, they receive little or no direct financial support from the church.

We believe the administration's budget proposal is a breach of faith with the hospital community and will result in hospital staff reductions, thereby eroding the quality of care, reducing funds available for charity care and exacerbating a tendency toward a two-tier health care system. Accordingly, the APHA is opposed to the administration's budget which would arbitrarily slash funding for the Medicare and Medicaid programs by $4.1 billion and $1.0 billion, respectively. For instance, the administration's budget proposes to freeze the annual increase in the prospective payment system [PPS] rates for hospitals. Under the current law, the increase in the PPS rates for fiscal year 1986 is limited to the market basket of hospital goods and services plus one-quarter of 1 percent. Thereafter, the annual increase is limited to market basket plus 1 percentage point. The Secretary of Health and Human Services has the discretion to set increases at less than the limit after considering the recommendations of the Prospective Payment Assessment Commission [PROPAC].

Under the proposed budget, the administration would bypass the Congress and by administrative fiat hold DRG rates at the fiscal year 1985 level. The Social Security Amendments of 1983, Public Law 98-21, require PROPAC to advise the Secretary on increases in PPS. PROPAC recently recommended that hospital payments be allowed to rise by 1 to 3 percent, which would result in a $600 million saving in fiscal year 1986. While it is true that the administration has the authority to set PPS rates, such authority is not unfettered, and the rejection of the recommendations of PROPAC, in advance, could be construed as arbitrary and capricious action. This itself is an indication of a breach of faith with the hospital community which participated in 1983 in a partnership with the Congress and the administration to create and implement PPS.

In addition, such a freeze would further reduce payments to hospitals which have already absorbed significant reductions in the past. Indeed, legislation enacted during the past four years has reduced Medicare spending by approximately $24.7 billion from projected levels. Now, following these already deep reductions, the administration's proposal would unfairly undermine hospitals, which already have contributed their fair share. Length of stay for Medicare patients has been reduced significantly, by 20 percent, since implementation of PPS, and the admissions are also down in fiscal year 1984 by over 4 percent from fiscal year 1983. Hospitals also have responded to the Medicare reductions by implementing programs that have reduced Medicare cost increases by 13 percent while continuing to provide high-quality care. By limiting DRG rates in light of these measures by hospitals, the administration has reneged on its commitment made in 1983, which requires that the rates be updated by reference to the market basket on an annual basis.

On top of these already disproportionate cuts, the administration has indicated that it will again seek to reduce the DRG weights when prices are set for fiscal year 1986. Thus, the total package reduction and the reduction of weights, coupled with the continuation of the PPS transition period in fiscal year 1986, will result in many hospitals receiving less in fiscal year 1986 than they received in fiscal year 1985. This, then, is not a freeze.

The proposed budget would go further to "freeze" payments for direct medical education and cut by half the indirect teaching adjustment. Payment for direct medical education is a cost passthrough and the indirect teaching adjustment is a doubling of the pre-PPS adjustment factor, currently 11.59 percent. The administration proposes to cut that by 50 percent. While APHA does not object to some fine tuning of the indirect adjustment, there is no justification to support cutting it in half, especially since it was implemented in 1983 because the DRGs do not recognize a severity of illness factor—a conspicuous omission which still has not been corrected by the administration. On the direct medical education side, the administration proposes to reduce the direct payment cost passthrough to what each hospital received in fiscal year 1984, not fiscal year 1985. Moreover, the administration's proposal is indefinite and not limited to 1 year. In addition, since the direct cost passthrough is mandated by statute, APHA believes that the administration may not freeze the direct cost passthrough, absent legislation. Indeed, the administration recognizes that it may not reduce by half the indirect teaching adjustment without legislation. Although the reductions in the indirect teaching adjustment are part of a "freeze" package, they will result in a real cut of about $700 million below what was spent in 1985: clearly, not a freeze by anyone's definition.

Moreover, the budget proposal must not be viewed in isolation: The administration has failed to implement to date the adjustment for those hospitals which serve a disproportionate share of low income or Medicare beneficiaries; the administration has failed to complete an indepth study of the case mix index, as promised in August 1984, to determine whether hospitals are treating sicker patients under PPS; the administration has yet to complete the study and development of a severity index to determine whether the resources which are used to treat a medicare patient within a particular DRG necessitate adjustments; the administration has yet to deliver to the Congress a proposed capital payment plan for Medicare; and it has only recently presented to the Congress a revised area wage index.

Medicaid, health insurance for the needy, is also slated for significant reduction by the proposed budget which would cut $1 billion in payment to States under the program. These cuts in the Medicaid Program also will have a direct impact on hospitals and this must be taken into account in understanding the Medicare budget. States have taken steps to reduce their medical costs and should not now be penalized with reductions in the vital Federal share of the Medicaid Program. While the Federal share has declined sharply for the past 4 years, there is an increasing indigent care case load in many areas. The proposed cuts, therefore, would deprive the most needy of vital medical services, thus resulting in significant financial hardship to hospitals that will continue to provide indigent care. The APHA hospitals are committed to providing these vital community services, including the several APHA hospitals which are teaching hospitals and as such serve a higher percentage of the severely ill and medically indigent.

In summary, the hospital community, under the administration's budget, is being required to make a disproportionate sacrifice and will bear a disproportionate burden in reducing the Federal deficit. The unfairness of the administration's proposal is demonstrated by the fact that only 20 percent of the budget savings would come from actual program freezes, while 10 percent of all cuts would come from Medicare and Medicaid. Hospitals, including APHA, do not object to contributing their fair share, but the Federal deficit reduction program should include all sectors of the economy and the Government.

It is disingenuous to assert that this is not a policy year for Medicare but merely a budget year. The administration's proposed budget would, if not revised by this committee, implement a new policy for medicare, without the benefit of a robust public debate. There is no justification for such a rush to judgment because even the most pessimistic estimate of the Medicare trustees does not contemplate a depletion of the Hospital Insurance Trust Fund until 1992. Moreover, this budget violates the commitment made to hospitals in enacting PPS. The budget cuts, if allowed to be implemented, would place in severe jeopardy the ability of hospitals to continue to provide the highest quality of care and access to such care to the 27 million elderly, 3 million disabled and 22 million indigent patients.

Accordingly, the APHA is opposed to the arbitrary Medicare reductions for the most crucial area of health care because of the potential deleterious consequences to patients. Indeed, these disproportionate reductions would adversely affect those who could least afford health care but are most in need of such services—the elderly and the poor. Not only would these reductions jeopardize access to health services, but they also threaten to erode the high quality of the Nation's health care system. Under this budget many hospitals simply will not be able to continue the same level of services to all patients following on the $24.7 billion reduction which has already occurred in Medicare spending during the past 4 years.

The APHA wishes to stress that it will continue to work with the Congress and the administration to devise a fair health care budget which will serve to reduce the deficit without jeopardizing the availability and quality of necessary and appropriate health services to Medicare and Medicaid patients.

Again, APHA appreciates this opportunity to testify and I will be pleased to answer any questions.

Mr. PICKLE. Now, Mr. Bromberg, the Chair will recognize you up to 5 minutes.

STATEMENT OF MICHAEL D. BROMBERG, EXECUTIVE DIRECTOR, FEDERATION OF AMERICAN HOSPITALS

Mr. BROMBERG. Thank you, Mr. Chairman. We appreciate this opportunity to testify on behalf of the 1,200 investor-owned hospitals with more than 140,000 beds. I will try to summarize it. I would like to, for the record, state one fact which I have not heard yet today which may or may not be relevant to this process, but the fact simply is that the Medicare Trust Fund has not contributed one penny to the Federal deficit. Notwithstanding that we are as an industry ready to do our fair share in bringing the Federal deficit down and know that we will be part of that process.

Second, I would like to answer a question you asked before about whether the DRG Program has been successful. One fact which certainly shows that it has been successful is that in fiscal year 1984, Medicare part A expenditures were $2.2 billion or 6 percent less than projected by the trustees of the Medicare Trust Fund. We supported that program and we continue to support it, the DRG Program.

However, we are here today to raise the caution that if a freeze is put on and if arbitrary prices are set, that successful program will be totally undermined and hospitals will be forced to cut the intensity of service to beneficiaries and to adopt more confrontational postures with respect to the Government.

In order to explain that, on pages 5 to 8 of our testimony we have tried to list in order of priority or likelihood nine actions which hospital managers, we believe, would have to seriously consider if a freeze were enacted. Some of this is based on exactly what we have done in the past year or more and in fact the Medicare Program cuts for the next 3 years are about what they were the last 3 years in terms of the budget.

Number 1 clearly is to reduce the work force since labor costs are 50 to 60 percent of hospital costs, and since 100,000 jobs no longer exist in an industry that employs 3 million people, the very first step that would have to be seriously considered would be further reduction of that work force.

However, that is a step that can be taken once, but it is very hard to do a second time without affecting quality. Second, normal wage increases would have to be reduced. Third, postponement of modernization of the plant. We would point out there is no more Hill-Burton Program, and that since 1946 when that program was enacted, we now have a situation today where about 40 percent of all beds in this country are 30 years old or older which means massive renovation needs, further postponed, which could prove inflationary in the long run.

Four, to postpone the replacement of obsolete equipment and purchase of new technologies, some of which could involve technology which could be cost efective. Five is postpone or eliminate services which you have heard from other witnesses. Six, reduce supply inventories which have been drastically reduced in the past 18 months.

Seven, increase pressure on physicians to further reduce the length of stay. While we do believe that some of the reports in the media and the GAO report interpretations have been somewhat exaggerated, it certainly is a situation that bears close watching. Eight, increase prices to non-Medicare patients, something we would have done clearly 2 years ago had we been testifying here that would have been No. 1 on our list, but in a price competitive environment, we are now in, that is next to impossible.

Nine, increase charges to Medicare patients themselves. If the Congress will not consider allowing us to do it with respect to those beneficiaries with incomes above $25,000 or who are able to afford some additional contribution, then at least doing it for Medicare noncovered services.

All of these options have in common the fact they are difficult to implement. They could be dangerous to quality, and they are unfair relative to the rest of the economy which does not have a price freeze. Of course, it will differ from hospital to hospital.

In conclusion, let me say that the goal of prospective payment was to encourage increased productivity and to reward efficient behavior. Many hospitals have dramatically cut their costs as you have heard from prior witnesses, and yet now they believe out there that the real reward they are going to get for bringing their price increases down from 17 percent to 4.5 percent is going to be a penalty. On the other hand, I would point out that Congress created the Prospective Payment Assessment Commission specifically to resolve this debate you are hearing today, to resolve or arbitrate a dispute between hospitals or providers who want it all and the Government who doesn't want to give anything. And we hope that you will seriously consider the recommendations of PROPAC. And we are pleased that they are testifying tomorrow. Thank you very much.

[The prepared statement follows:]

STATEMENT OF MICHAEL D. BROMBERG, EXECUTIVE DIRECTOR, FEDERATION OF AMERICAN HOSPITALS

SUMMARY

The Federation of American Hospitals is willing to accept our fair share of responsibility in any attempt to reduce the Federal deficit. However, the cuts for the Medicare program proposed by the Administration go far beyond any sense of fairness and proportion. The proposed reductions in Medicare are far greater than those suggested for any other federal program—nearly $20 billion. Consequently, health care providers will be asked to absorb much more than their fair share of the reductions.

During the period of 1981 to 1983, the nation's hospitals absorbed over 50 percent, approximately $10 billion, of all the Medicare cuts enacted by Congress. Last year's Deficit Reduction Act contained further substantial decreases in Medicare payments to hospitals. Simultaneously hospitals came under a tough new "prospective payment" system encouraging a new cost cutting competitive spirit in the health care market place.

Clearly, the Medicare hospitals prospective payment plan is working. Hospitals have responded to the new incentives by cutting their expenditures. In fiscal 1984, for example, actual Medicare Part A spending was $2.2 billion or 6 percent less than orginally projected by the trustees of the Hospital Insurance (Part A) Trust Fund.

If there is a freeze in hospital payments for fiscal year 1986, hospitals will be forced to review cost cutting options for example:

Reduce work force; reduce normal wage increases; postpone modernization of hospital plant and replacement of obsolete equipment; postpone or eliminate services; increase prices to non-Medicare patients; and increase charges to Medicare patients.

More importantly, a Medicare payment freeze will severely undermine a program that is working.

STATEMENT

The Federation of American Hospitals is the national association of investor-owned hospitals and health care systems representing over 1,200 hospitals with over 140,000 beds. Our member management companies also manage under contract more than 300 hospitals owned by others. Investor-owned hospitals in the United States represent approximately 25 percent of all non-governmental hospitals. In many communities, investor-owned facilities represent the only hospital serving the population.

The Federation of American Hospitals is willing to accept our fair share of responsibility in any attempt to reduce the Federal deficit. However, the cuts for the Medicare program proposed by the Administration go far beyond any sense of fairness and proportion. The proposed reductions in Medicare are far greater than those suggested for any other federal program—nearly $20 billion. Consequently, health care providers will be asked to absorb much more than their fair share of the reductions.

The Administration and Congress should note that the Medicare Hospital Insurance Trust Fund does not contribute to the Federal deficit. Payments to hospitals under Medicare do not come from general revenues; they are financed by a payroll tax. A severe reduction in payments however, will force hospitals to consider reductions in services.

The pending bankruptcy of Medicare can no longer be held out as a legitimate reason for drastic cuts in the program. The projected date for the insolvency of the Medicare Trust Fund is now beyond 1998, 8 years beyond last year's projection—primarily because hospital cost increases are dramatically lower than projected levels.

During the period 1981 to 1983, the nation's hospitals absorbed over 50 percent, approximately $10 billion, of all the Medicare cuts enacted by Congress. Last year's Deficit Reduction Act contained further substantial decreases in Medicare payments to hospitals. Simultaneously hospitals came under a tough new "prospective payment" system encouraging a new cost cutting competitive spirit in the health care market place.

Hospitals have responded to these cutbacks by saving the Medicare program literally billions of taxpayer dollars through the implementation of sound management procedures designed to provide high quality care at a reasonable price. Previously hospital costs were increasing at annual rates of increases as high as 17 percent. However, this is no longer the case. Due to the more careful management of admissions, labor costs and utilization of facilities, the hospital industry has succeeded in bringing hospital costs down dramatically. In 1984, the annual rate of increase was only about 4.5 percent or approximately the same as the general inflation rate.

Clearly, the Medicare hospital prospective payment plan is working. Hospitals have responded to the new incentives by cutting their expenditures. In fiscal 1984, for example, actual Medicare Part A spending was $2.2 billion or 6 percent less than originally projected by the trustees of the Hospital Insurance (Part A) Trust Fund.

Hospitals have demonstrated that with appropriate incentives, they will vigorously cut costs, but there is a problem. While they understand the need to accept their fair share of budget cuts, many hospitals question whether the federal government will make a good faith effort to live up to its commitments. When the Social Security Amendments of 1983 (P.L. 98-21) were passed, hospitals were told that:

They would be paid a fixed price per diagnosis and would be allowed to keep the difference between their cost and what they were paid.

Their payment rates would be increased annually by the increase in the cost of their inputs (the hospital market basket) plus 1 percent for technology upgrading.

Congress in the Deficit Reduction Act of 1984 (P.L. 98-369) reduced the technology factor to 0.25 percent. At the same time, the limited the annual increase in hospital payments to the actual input cost increase, the market basket, minus 1.05 percent on the theory that hospitals were reporting an unjustifiable increase in the number of higher complexity and therefore higher paying cases. Hospitals argued that the more complex case mix was the result of more accurate coding and was a one time phenomenon. Now for fiscal 1986 HHS is proposing an administrative freeze on payment rates to hospitals.

If Congress and the executive branch impose a disproportionate share of the burden of budget cuts on hospitals, it will represent a breach of faith on the part of the Administration and Congress. It will undermine a successful program and discourage hospitals from working with their staffs, physicians and patients to continue their efforts in adapting to the new system. Hospitals will be forced to cut the intensity of service to Medicare beneficiaries or to adopt a more confrontational posture. Cooperation, essential to patients' receiving the greatest value for the dollar, will be replaced by mistrust and acrimony.

Congress as part of the prospective payment legislation, created the Prospective Payment Assessment Commission to avoid the conflict of unreasonable demands for payment on the part of hospitals and inappropriate budget slashing on the part of the Administration. Consequently, we feel Congress should consider the increase in hospital payments recommended by this independent commission as a floor on payment rates. Congress should prohibit the Administration from administratively reducing rates below a legislated level.

If there is no increase in hospital payments for fiscal year 1986, the impact of such a provision would vary according to individual hospital costs. The loss of the anticipated (approximately 5 percent increase in payments will force hospitals to review the following options in the order presented:

REDUCE WORK FORCE

Labor costs comprise 50 to 60 percent of hospital budgets. Hospitals have already reduced their workforce by 100,000 employees, down from 3 million. Such a reduction will not be easy to implement again and could adversely affect quality and quantity of nursing care and personal attention to patients. Hospitals to meet these cost restraints may have to turn to employees with lower level qualifications, to perform more services.

REDUCE NORMAL WAGE INCREASES

If hospital payments are frozen, the adverse impact on employee wages is inevitable. Hospitals also will risk losing qualified employees to other industries not subject to such frozen prices and able to pay competitive salaries.

POSTPONE MODERNIZATION OF HOSPITAL PLANT

Hospital plants are aging. Forty percent of all hospital beds are at least 30 years old. Hill-Burton grants are no longer available. Although capital costs are still paid by Medicare on a pass-through basis, payments for operating costs would be frozen under the Administration's budget. Hospitals therefore cannot incur additional operating costs associated with upgrading their facilities. Furthermore, lending institutions, given the proposed freeze in hospital payments will be less likely to lend hospitals money when there appears little certainty about their long term ability to receive a fair and consistent payment from government programs.

POSTPONE REPLACEMENT OF OBSOLETE EQUIPMENT AND PURCHASE OF NEW TECHNOLOGY

As stated previously, while capital costs continue to be cost reimbursed, operating costs generated by those capital expenditures are paid prospectively. The administration's proposed freeze in hospital payments will result in the decision by hospitals either not to purchase new equipment, or to postpone such purchases which will result in later higher expenditures.

POSTPONE OR ELIMINATE SERVICES

Hospitals will to postpone new services or eliminate certain community services which may not prove cost effective, such as neonatal units and burn units. Essentially, some hospitals will have to change the way they currently provide healthcare.

REDUCE SUPPLY INVENTORIES

Hospitals have already altered their purchasing and inventory patterns. This has resulted in significantly financial pressure on hospital supply companies.

INCREASE PRESSURE ON PHYSICIANS

Hospitals will encourage physicans to further reduce patient lengths of stay by ordering more pre and post admission procedures. While the recent GAO report on early discharge of Medicare patients to post hospital care may have been blown out of proportion, the danger of premature discharges cannot be ignored.

INCREASE PRICES TO NON-MEDICARE PATIENTS

While in the past, many hospitals absorbed cuts in government programs by charging more to private paying patients, such activity is impossible in the current competitive environment. Private insurers and employers will no longer tolerate increases in premiums resulting from this type of cost shift. Consequently, most hospitals will have to cut labor costs and services to maintain their financial viability.

INCREASE CHARGES TO MEDICARE PATIENTS

Hospitals will have to consider increasing charges to Medicare patients for noncovered services such as television and telephone. Hospitals will also have to analyze their legal rights to charge Medicare beneficiaries for the cost of new technology or inflation, not recognized by Medicare.

All of these options have in common difficulty of implementation, danger to quality, and unfairness relative to the rest of the economy where there is no price freeze. Also there exists the danger of destroying a successful new set of incentives just when significant progress is being made.

There are viable and appropriate alternatives to the Administration's proposed freeze in hospital payments:

Extend the current cigarette excise tax rates with part of the revenues earmarked for the Medicare Hospital Insurance Trust Fund.

Relate the Medicare Part B premium to income by imposing a variable Part B premium tied to income.

Tax Medicare benefits of beneficiaries with incomes in excess of $25,000 ($32,000 per couple) similar to the recently enacted tax on Social Security benefits.

Pretending that health care is free does not help our Medicare beneficiaries. They are the ones who can least afford to suffer a decline in the quality of their health care. Indeed it may well be time for some of us to consider asking those Medicare beneficiaries who can pay for their health care to begin contributing to its costs.

Nobody likes the idea of a "means test" for Medicare. Nevertheless, the interests of fairness require some beneficiary contribution, according to ability to pay, if an equitable solution to the deficit is to be found.

In summary, hospitals have responded to the new incentives of the Medicare prospective payment system. The goal of prospective payment was to reward efficient behavior by hospitals. Many hospitals have dramatically cut their costs and yet now they are being threatened with further payment cuts. Further reductions in payments for some hospitals will change the way they have traditionally delivered health care. It is clear hospitals will cut their costs again, but one must consider what quality and quantity of health care we want for Medicare patients. More importantly, a Medicare payment freeze will severely undermine a program that is working.

Mr. **Pickle**. Thank you. Mr. Bromberg.

I take it that all three of you do not oppose the DRG system, that, in effect, you recommend that system and it is working well.

What you object to, I take it, much as anything, is the freeze that they would institute at this time on the program. Is that essentially what you are objecting to?

Sister **Lyne**. Yes.

Dr. **Umbeck**. Yes.

Mr. **Bromberg**. Yes.

Mr. **Pickle**. I noted, Sister, that you said you would oppose the freeze in the PPS rates.

Sister **Lyne**. Yes.

Mr. **Pickle**. Freeze on direct medical education and particularly elimination of the doubling in the direct teaching adjustment.

Sister **Lyne**. Yes.

Mr. **Pickle**. I assume that you primarily oppose that because it is a measure that the Federal Government is not really keeping its word on. They said they would pass through these costs, you would get the extra amount because it is needed, and now they are going to freeze it and take it away, not only freeze it but take it away in some cases. Therefore, the Government has not kept faith with what they said they would do. Is that essentially what you are saying?

Sister LYNE. Yes, and also because in the meantime we have not done any kind of research or further study. Granted it as somewhat nebulous when it was first put in, recognizing the increased costs in large urban teaching hospitals, the indirect one. Since that time there has not been further research on that so we still have time to do the research before another freeze is implemented.

Mr. PICKLE. We would need the research, I am sure. I don't know how we would handle, say, the doubling of the indirect teaching adjustment.

I understand, Sister, your hospital received nearly $3 million annually.

Sister LYNE. Yes.

Mr. PICKLE. Through this indirect teaching adjustment?

Sister LYNE. Yes.

Mr. PICKLE. That about the right figure?

Sister LYNE. $3 million?

Mr. PICKLE. Yes.

Sister LYNE. Yes.

Mr. PICKLE. Is that about the right figure?

Sister LYNE. Yes.

Mr. PICKLE. And what you want to do is maintain that but as it is, you might lose it all?

Sister LYNE. Yes.

Mr. PICKLE. If they eliminated it?

Sister LYNE. Yes.

Mr. PICKLE. I understand your position on that.

Mr. Bromberg, I appreciate the fact that you said you would be willing to try to help see if we can't find an adjustment on it even though Medicare wasn't the cause of the deficit?

Mr. BROMBERG. Mr. Chairman, I think it is ironic because I could have said the same about Social Security benefits because the same is true there but I think it is ironic that the compromise in the other body with the White House seems to be market basket minus 2 percent for Social Security benefits and that is exactly what ProPAC came up with for hospitals.

And I think hospitals could accept something like that across-the-board as a fair share if they thought defense and other parts of the budget were being cut, but we can't understand really, the people in the field can't understand why they were singled out in this way for a freeze when they have done a pretty good job of making this program a landmark program and making it work the way it has in the past year in light of other program cuts.

Mr. PICKLE. There is reason to raise a good question about the amount that the administration wants to raise, save, in the field of Medicare alone as contrasted to other approaches and some of us don't understand that either.

I don't know whether we agree with you or whether there can be any freeze or whatever, but I think you or Dr. Umbeck said we could do adjusting or fine tuning. That may be the approach.

Mr. Gregg.

Mr. **Gregg**. Thank you, Mr. Pickle.

Mr. Bromberg, can you tell me, do you have statistics on staffing of private hospitals versus staffing of public hospitals that are known teaching hospitals?

Mr. **Bromberg**. The staffing patterns have changed so much in the last 18 months that I would hesitate to give you data which is at best 2 years old, but in the past if you looked at national data and lumped all hospitals together it looked as if our full-time equivalent number of employees was at least six-tenths to eight-tenths of a point less than nonprofits.

However, I have also thought that data was really wrong because it never was adjusted for size. If you look at a 200-bed hospital for profit and 200-bed nonprofit, nonteaching, nonpublic, they look pretty similar to us.

However, a lot has been done in the last 18 months. That 100,000 number I used about lost jobs is about 10,000 in our industry as far as we can gather. We are about 25 percent of the non-Government hospitals but only about 15 percent of the beds.

So it is over 10,000 workers who have lost their jobs in our hospitals now. But FTE's were traditionally low which makes it harder to cut more. We are at the low edge already.

But generally, we are talking about being very close to the nonprofits when you get rid of things like teaching and really compare apples and apples and compare a 200-bed typical community nonprofit and for-profit hospital the data on all these look pretty similar.

When you use big national numbers it looks like our length of stay had been shorter, FTE's had been lower, and I also hesitate to say that is because we were efficient because a lot of it is a function of size.

Mr. **Gregg**. If that is the case and we have seen a drop in hospitalization, you would expect there would be a drop of staffing, wouldn't you? A 100,000 drop in personnel staff—is not consistent with the percentage of drop in utilization. That is not a 6-percent drop in staffing.

Mr. **Bromberg**. No, it is 3 percent. It is more because it had been going up at 3 percent a year because of technology and intensity of services.

In other words, when you added certain kinds of therapy to your ancillary departments in the hospital you had to hire more sophisticated technicians and more workers. Until 2 years ago, it was going up at the rate of 3 percent a year until it reached 3 million, then suddenly, it turned around and there was a 3-percent drop which is where your 100,000 comes in.

Second, I want to be clear. I wasn't criticizing that. I think it's good. I think we got some of the so-called fat out of the system and perhaps some of the featherbedding that cost reimbursement perpetuated because when the Government told us they would pay costs we had no management incentive to not keep the work force very high.

My point is once you do it, as we did over the past year and a half to 2 years, it is very hard to go in and do it again because once you get the fat out you start to cut into the bone or cut into the quality of service. I can't tell you where that magic line is, but we are very fearful we are fast approaching it.

Mr. **Gregg**. Well, if the freeze went into place, is anybody suggesting that the hospital organizations drop out of the Medicare system?

Sister **Lyne**. No.

Mr. **Gregg**. It wasn't so much the hospitals' desire to comply as the decision that Medicare was going to go to prospective payment that really drove the decision, and the efficiencies that have occurred here.

Mr. **Bromberg**. That is it exactly—we agree with that. We supported the system. Yes, we finally got the incentive to become more efficient, and we have delivered, but if you penalize us now for it, we are never going to believe it again, and the good manager is going to be the one who keeps his price right at the middle, because in the past, they thought the rules had changed, and now they will think we are going back, and that could be a pretty dangerous step.

Mr. **Gregg**. How do we know we are at that point where the lines cross on the graph?

Mr. **Bromberg**. We don't, and we don't want to come in here and cry wolf. You asked about Medicare, to set the record straight, when the Medicare law was enacted, physicians had the right to charge the Medicare patient over and above the rate, the hospitals were always told that they had to accept Medicare payment as payment in full, and because it is anywhere from 25 to 50 percent of our total patient population, Medicare beneficiaries we don't even have the option of pulling out of the program.

The only option we have is going bankrupt, cutting services, cutting work force, postponing modernization, not replacing equipment.

However, we are going to have to review that policy if this continues and ask our lawyers whether we really are barred from charging over and above the rate, something we already asked our counsel to look into.

Mr. **Gregg**. Another option might be merging and weeding out underutilization.

Mr. **Bromberg**. I agree with that. A lot of us are looking to be not strictly in the hospital business anymore, but make sure we don't add costs by adding home health, capitating it, going into the HMO, preferred provider business and diversifying.

It may mean we just won't put a lot of capital into hospitals, even though they need it. I think the Medicare, HMO, option is probably going to be a greater landmark than the DRG. There are still hospitals who need capital to maintain quality, and this freeze on their operating costs is going to freeze medical technology and prevent them from improving.

Mr. **Gregg**. Thank you.

Mr. **Pickle**. Well, we thank each one of the panelists and all of you who appeared this afternoon. The committee wanted to get on record statements from the various associations we have heard today, and each of you, I say this to the last panel, you have given us very valuable information and testimony. We appreciate it.

The subcommittee will stand adjourned.

[Whereupon, at 3:35 p.m., the subcommittee was adjourned.]

1986 MEDICARE BUDGET ISSUES

TUESDAY, APRIL 16, 1985

House of Representatives,
Committee on Ways and Means,
Subcommittee on Health,
Washington, DC.

The subcommittee met, pursuant to notice, at 9:40 a.m., in room B-318, Rayburn House Office Building, Hon. Fortney H. (Pete) Stark (chairman of the subcommittee) presiding.

Chairman Stark. If I could have your attention. We have called for more chairs. When they come, as a courtesy to our witnesses, if you all could kind of spread the chairs in and take your seats quietly, we will resume the hearing.

And the subcommittee will convene.

Our first witness this morning is Stuart Altman, Chairman of the Prospective Payment Assessment Commission, professionally known as old 2½ percenter. We were wondering whether we will only give you 2½ minutes, but he tells me that he has a 15-minute speech and it will take him about an hour to deliver it.

So, Stuart, we welcome you to the committee. And we have your prepared testimony which will appear in the record in its entirety. And you may proceed in any manner you desire.

STATEMENT OF STUART ALTMAN, PH.D., CHAIRMAN, PROSPECTIVE PAYMENT ASSESSMENT COMMISSION, ACCOMPANIED BY DONALD A. YOUNG, M.D., EXECUTIVE DIRECTOR

Mr. Altman. Thank you, Mr. Chairman. It is a pleasure.

The Prospective Payment Assessment Commission is the product of your committee's work 2 years ago, and this is the first opportunity we have had to appear before you.

I am accompanied this morning by Dr. Donald Young, who is the Executive Director of the Commission. And we are pleased to testify before this subcommittee today about the recommendations of the Commission in its first report to the Secretary of Health and Human Services.

Several of our major recommendations relate to your hearings on the fiscal 1986 Medicare budget. Before I describe the Commission's recommendations, let me briefly provide you with some general information about ProPAC.

The Commission, as you know, was established by Public Law 98-21, and the Social Security Act of 1983, which also enacted the Medicare PPS system. The members were appointed by the Director of the Office of Technology Assessment in December 1983, and the staff was recruited over the last year.

Over 25 meetings have been held by the Commission and its three subcommittees since our appointment. And we have been focusing on the issues that you directed us to review.

As you may remember, our legislative mandate designated that we concentrate our efforts on two primary activities and that we deliver our first annual report on April 1.

And I might say that this is probably the first time in my history that I actually met a deadline. I think that speaks well of the staff we recruited. Because the Commission—or at least its chairman—often fails in that respect.

In that report we focused on what we believe to be the appropriate annual increase in the standardized rate, or what we call the update factor. And our second mandate was to make recommendations with respect to specific changes in the diagnosis related groups, including changes that should come about because of new types of technologies or procedures.

Both of these responsibilities and our recommendation have a significant relationship to the subject of your hearing today I believe.

First let me say that the Commission is very optimistic about the success of the PPS system thus far. And we believe as it is operating so far it is basically sound. Our recommendations have suggested improvements in areas where we have identified critical problems. As a governing philosophy, we have not attempted to recommend changes for change sake; rather we have focused on areas that really seem to need change right away.

Overall the recommendations seek to balance the need to restrain Federal expenditures with the need to maintain the Medicare patients' access to quality care. And we took quite seriously the charge you gave us, that is that our recommendations should be consistent with maintaining access and maintaining high quality care.

As indicated on page 3, we focused and were guided by five major principles. The first I mentioned, to maintain access to high quality care. The second is to encourage hospital productivity and particularly long-term cost effectiveness.

As you will see, if you review our report, we are very concerned about the long run as well as short term budgetary impact. The third area is to facilitate innovation and appropriate technological change.

We were convinced that you did not mean in establishing the PPS system to freeze the health care system in place as it existed in 1981, and therefore we have taken great pains to develop enough capacity for the industry to move ahead.

The fourth area is to provide stability for providers, consumers, and other payers. In my experience in this field instability is what causes a lot of problems because no one knows what is going to happen next. And that is not good for the system.

And finally, we have tried where possible to use reliable and timely data and information for decisionmaking.

The Commission's recommendation on the update factor is clearly the most important in light of the subject of the hearing today. ProPAC has recommended an increase in the Medicare in patient hospital rates for fiscal year 1986 equal to the hospital market basket, minus 1 percentage point, plus adjustment for real case mix.

As you have indicated, some have figured that this will be about a 2.5-percent increase.

Now, we are a little more hedging on our figures, and we believe it will be between 1 and 3 percent. But I want to emphasize here that in comparison to a zero, that's a high number. If you judge it in comparison to historical trends, however, our recommendation is 3 to 5 percentage points below what the hospital industry has gotten from the Medicare program. And I think one needs to balance those various numbers.

This recommendation represents the Commission's best judgment as to the net change in the payment that will both restrain the rate of increase but also provide payment for funding scientific and technological advances the hospital industry should have.

We also have tried to build in a positive incentive for the hospitals to continue to be more productive. In particular the Commission's calculations reflect the judgment and belief that appropriate, sustained, and necessary technological growth in the health care industry can be achieved in part by savings generated through improvements and hospital productivity.

In the second major area of our responsibility which relates to changes in the DRG classification and weights, the Commission has examined a number of individual technologies and practices. We have also recommended recalculating all of the DRG weights using newer, more complete, and more accurate Medicare patient billing, which is the Patbill data.

This recalibration is intended to enable the PPS system to reflect changes in hospital practices during recent years. As part of the recalibration process, we have also recommended that the weights should be adjusted to avoid building changes in coding practices into future PPS payments. I will be glad to talk about that because I know it is a controversial and complicated subject.

As a result of its review of the update factor, the Commission has recommended action on two problem areas arising from the PPS implementation which I believe are also of particular interest to the members of the subcommittee. Specifically, the Commission urges the Secretary of the Department of Health and Human Services to move quickly to improve the current definition of the hospital labor market area in order to better adjust PPS rates for area wage differences. In this recommendation we suggest that variations in wages paid in the inner city compared to suburban areas within a metropolitan area and in different rural areas within a State should be considered—or I might say reconsidered because we believe the current definition is faulty in several respects.

In addition, the Commission urges the Secretary to institute adjustments for hospitals that incur higher Medicare costs per case associated with treating a greater proportion of low income patients, the familiar disproportionate share hospital issue.

This recommendation includes development of a method for defining disproportionate share hospitals. And the Commission has indicated that the new definition should be completed in ample time to allow for adjustments in the fiscal year 1986 PPS rates.

I know that because of your responsibility with regard to the 1986 budget proposals you are interested in how our recommendations can be quantified. In other words, What is the bottom line? And that is what I have tried to give you before.

But I will add that it is difficult for us to make any clear statement about what that bottom line is because in part our recommendations still await some numbers that must come from the administration. Specifically ProPAC believes that changes in hospital case mix, which are the result of treating——

Chairman **Stark**. Excuse me. What numbers are those? We are looking for some numbers too.

Mr. **Altman**. Well, as I have indicated, inflation, or the market basket number, is a fairly easy number to calculate and will come out of the computers at some appropriate time. Probably the market basket will be in the 4½- to 5-percent range.

Then we have recommended a 1 percentage point reduction from that. So that will bring you down to 3, 3½ percent.

But we also recognized there is this complicated area of case mix. And we believe that the coding increases which are not due to sicker patients should be subtracted from that number. We further believe, however, that we should add back in an appropriate adjustment for coding increases which result from the fact that some hospitals are treating sicker people. And it is in this area of coding change that we don't yet have percentage figures.

And the administration is preparing a report on that. And what we have suggested in our report is that at the time those numbers come out, we will review them. They probably will lead to a couple of percentage point reductions further in our estimates. And that is where you——

Chairman **Stark**. That is the disproportionate——

Mr. **Altman**. No. That is the result of the fact that the coding has been creeping up, in part due to more sophisticated practices being employed by the hospitals, which turns out to be somewhat less than random.

Chairman **Stark**. Thank you.

Mr. **Altman**. I know that because of your responsibilities with regard to the 1986 budget these numbers are important. And that is why we focus so much on them.

Now, in addition, we have gone into a number of other areas. And rather than read all the 21 recommendations I will just, if it is all right with you, provide the full text for the record.

Our task in this first year has been enormous. But I am really quite pleased with what we have accomplished. And I hope you have been.

I want to mention briefly that the future agenda for ProPAC is quite large. And we have also indicated in chapter 4 of our report a complete list of what we hope to focus on.

I might add that we have been working closely with your staff on this agenda. And as you go through these committee hearings, if you focus on other areas that you would like us to look into, do not hesitate to have your people call us, and we will try to accommodate your needs where we can.

Our hope is in the future to get a better fix on this case mix issue as well as a variety of other problems which are, as I said, listed in that chapter.

Finally, we will also be continuing our analysis of the PPS payment policies, including emphasis on adjustments for differing costs of hospitals serving large numbers of low income patients. We will also be continuing analysis of the definition of hospital labor markets, and of the issue which is causing a good deal of controversy; that is, the effect of slowing down the transition to complete national rates.

Let me pause to mention a bit more about ProPAC's discussions and concerns with the PPS transition. I believe it is fair to say this issue represents an area in which the Commission does not have a consensus as to the appropriate course of action.

Therefore, while we are making no recommendations at this time on the pace of the transition to national rates, the Commission is acutely aware of concerns that have arisen regarding the impact of the transition on different hospitals and different regions of the country and the Commission believes that additional data and analysis in this area is extremely important.

Therefore, the Commission has committed itself and its staff to provide a more detailed report by the early summer. And we hope that the information will be helpful to you in deciding whether it really is appropriate to slow the transition down.

In closing let me say that we hope that we have been able to seek a sensible balance between the tensions of, on the one hand, reducing the weight on the Federal budget of constant increases in Medicare hospital payments and, on the other, trying to recognize that this is an important industry critically important to our Medicare beneficiaries, and that it is important that we maintain quality and effectiveness and access.

Thank you, Mr. Chairman.

[The prepared statement and Commission recommendations follow:]

STATEMENT OF STUART ALTMAN, PH.D., CHAIRMAN, PROSPECTIVE PAYMENT ASSESSMENT COMMISSION

Mr. Chairman, I am Stuart Altman, Ph.D., Chairman of the Prospective Payment Assessment Commission. I am accompanied today by Donald A. Young, M.D., Executive Director of the Commission. We are pleased to testify before this subcommittee today about the recommendations of the Commission in its first Report to the Secretary of Health and Human Services. Several of our major recommendations relate to your hearings on the fiscal year 1986 Medicare budget.

Before I describe the Commission's recommendations, let me briefly provide some general information about ProPAC. The Commission was established by Pub. L. 98-21, the Social Security Act Amendments of 1983 which also enacted the new Medicare Prospective Payment System. Members were appointed by the Director of the Office of Technology Assessment in November 1983 and began meeting in December 1983. Staff was recruited and the Commission became fully functional in 1984. Over 25 meetings have been held by the Commission and its Subcommittees since our appointment to consider the important tasks assigned to us under the law: the updating and maintenance of the Medicare prospective payment system.

Our legislative mandate designates that we concentrate our efforts on two primary activities and address them in our annual April 1 report to the Secretary of Health and Human Services. The first of these responsibilities requires us to recommend annually to the Secretary the appropriate percentage change in the Medicare payments for inpatient hospital care, called the "update factor," which is applied to the previous year's payment rates. The second mandated responsibility calls on us to consult with and recommend to the Secretary necessary changes in diagnosis-related groups (DRGs), including advice about establishing new DRGs and changing the relative weights of the DRGs. Both of these responsibilities and our recommendations have a significant relationship to the subject of your hearing today.

The Commission is very optimistic about the success of PPS, and we believe the basic system is sound. Our recommendations have suggested improvements in areas where we identified critical problems, and the report also outlines important areas for future study. Overall, the recommendations seek to balance the need to restrain Federal expenditures with the need to maintain Medicate patients' access to high quality care.

In developing its recommendations the Commission was guided by five major priorities which cross-cut all of our work. I anticipate that these priorities will continue to govern our activities, for the Commissioners feel very strongly about them.

These priorities are:

Maintaining access to high-quality health care for Medicare beneficiaries; encouraging hospital productivity and long-term cost-effectiveness; facilitiating innovation and appropriate technological change; providing stability for providers, consumers, and other payers; and using reliable and timely data and information for decision making.

The Commission's recommendation on the update factor is most important in light of the subject of your hearing today, so let me discuss that recommendation first. ProPAC has recommended an increase in Medicare inpatient hospital rates for fiscal year 1986 of the market basket minus one percentage point, plus and adjustment for "real" case-mix change. This recommendation, if accepted, would result in payment increases significantly less than those of recent years.

This recommendation represents the Commission's best judgment as to the net change in payments needed to provide scientific and technological advances in the hospital industry, balanced by changes in hospital productivity, changes in the services provided by a hospital, and any change resulting in sicker Medicare patients being treated in hospitals. In particular, the Commission's calculations reflect a judgment and belief that appropriate, sustained, and necessary technological growth in the health care industry can be achieved in part by savings generated through improvements in hospital productivity.

In the second major area of our responsibility, relating to changes in DRG classification and weights, the Commission has examined a number of individual technologies and practices and has recommended recalculating all of the DRG weights using newer, more complete, and more accurate Medicare patient billing (PATBILL) data. This recalibration is intended to enable PPS to reflect changes in hospital practice during recent years. As part of the recalibration process, we have also recommended that the weights should be adjusted to avoid building changes in coding practice into future PBS payments.

As the result of its review of the update factor, the Commission recommended action on two problems arising from PBS implementation which I believe are also of particular interest to members of the Subcommittee. Specifically, the Commission urged the Secretary of the Department of Health and Human Services to move quickly to improve the current definition of hospital labor market areas, in order to better adjust PS rates for area wage differences. In this recommendation, we suggest that variations in wages paid in the inner city compared with suburban areas within a metropolitan area and variations paid in different rural locations within a state should be considered. In addition, the Commission urged the Secretary to institute adjustments for hospitals that incur higher Medicare costs per case associated with treating a greater proportion of low income patients ("disproportionate share hospitals"). This recommendation includes development of a method of defining disproportionate share hospitals and the Commission has indicated that the new definition should be completed in ample time to allow for adjustments in the fiscal year 1986 PPS rates.

I know that because of your responsibilities with regard to the 1986 budget proposals you are interested in how our recommendations can be quantified—what is our bottom line? This is difficult because ProPAC's recommendations rely upon the Secretary to make certain estimates of case-mix changes based on information not available at the time of the Commission's decision-making and report. Specifically, ProPAC believes that changes in hospital case mix which are the result of treating sicker Medicare patients during 1985 should be added to the update factor of market basket minus one percentage point. On the other hand, in our recalibration recommendation, we have suggested that all reported case-mix change during 1985 should be removed from the DRG weights as part of the recalibration process.

If the Commission's recommendations were accepted and implemented, the net effect would, we believe, result in an overall increase in PPS rates for next year of about 1-3 percent. This amount is significantly less than rates of increase experienced in past years, but more, of course, than the freeze proposed by the Administration. This amount is a judgment which the Commission believes is necessary for the efficent and effective delivery of medically appropriate care of high quality. Further, the Commission believes that adoption of these recommendations will result in substantial improvements in PPS which will maintain the essentially positive experience of the system to date.

Rather than go into detail on all of our 21 recommendations, I would like at this time to submit for the record the full text of the recommendations and discussion of each.

Our tasks in this first year have been enormous, but I am extremely pleased with the work of the Commission to date. I want to mention briefly, however, the future agenda for ProPAC, for we have many critical issues yet to analyze and address. Among the most important areas we will be considering in coming months are: refinement and evaluation of case-mix measurement systems, including alternatives to the DRG system; improvement in the methods used to account for resources consumed during specific types of hospital stays with special emphasis on analyzing the allocation of nursing costs to DRGs; system responsiveness to changes in medical practice patterns, focusing on payment mechanisms for new or changing technologies; and the effects of PPS on health care delivery, such as changes in quality of care and health outcomes, changes in types of patients treated in hospitals, changes in the hospital product, and variation in regional practice patterns.

Finally, we will also be continuing our analysis of PPS payment policies, with emphasis on adjustments for differing costs of hospitals serving large numbers of low income patients, definitions of hospital labor market areas, and effects of the transition to national payment rates.

Let me pause to mention a bit more about ProPAC's discussions and concerns with the PPS transition. I believe it is fair to say this issue represents an area in which the Commission does not have a consensus as to the appropriate course of action. Therefore, while making no recommendation at this time on the pace of transition to national payment rates, the Commission is acutely aware of concerns that have arisen regarding the impact of this transition on different hospitals and regions and believes that additional data development and analysis in this area is extremely important. The Commissioners believe that the transition issue involves weighing the desirability of continued implementation of a system already clearly yielding positive results against the possible benefits of delying the transition to correct PPS inequities and shortcomings. At our next scheduled meeting in July, the Commission will reexamine the transition issue based on analysis already requested and underway by the staff.

In closing, let me say that I believe that ProPAC's recommendations seek to address as sensibly as possible the tension among several compelling and competing considerations: Federal budgetary constraints; maintenance of access to high-quality care; and changes in the hospital industry. It is our judgement that we have achieved a reasonable balance among these considerations, and we hope our work will assist in the development of sound public policy. Thank you for this opportunity to present a summary of the work of ProPAC during its first year. I would be pleased to answer any questions you may have about our work.

RECOMMENDATIONS

The Commission's priorities and concerns described in Chapter 2 were evident throughout its first year and are reflected in the recommendations that follow. The recommendations are in two parts, following the Commission's statutory requirements: First are recommendations concerning the fiscal year 1986 "percentage change-" or update factor which determines the overall change in the PPS standardized amounts, exclusive of any other adjustments. Second are recommendations concerning adjustments to the "classifications and weighting factors" which determine relative changes in DRG payments. Discussion of these two types of recommendations is followed by a statement on the context in which the recommendations are made.

The major part of Chapter 3 consists of the Commission's 21 recommendations, each followed by a brief discussion of the rationale underlying the Commission's decisions. Details on background information, statistical analyses, and alternative options are contained in the Technical Appendixes.

THE UPDATE FACTOR

The statue requires the Commission to ". . . take into account changes in the hospital market basket . . ., hospital productivity, technological and scientific advances, the quality of care provided in hospitals (including the quality and skill level of professional nursing required to maintain quality care) and long-term cost-effectiveness in the provision of inpatient hospital services," in making its recommendations on the annual update factor. The Commission is required to report its recommendations to the Secretary of Health and Human Services no later than April first of each year, and ". . . Taking into consideration the recommendations of the Commission, the Secretary shall determine . . . the percentage change . . . which will take into account amounts necessary for the efficient and effective delivery of medically appropriate and necessary care of high quality."

The Commission has considered both aggregate payment amounts and the distributional effects of payment decisions on beneficiaries and hospitals in the belief that these effects are as important to the maintenance of high-quality care and to the achievement of other system goals as the level of the update factor. The Commission is concerned that an update factor which may be adequate on the average may be inadequate for certain types of hospitals and the Medicare beneficiaries who depend on these hospitals. Thus, some of the Commission's recommendatoins address the distributional consequences of the update factor and others the determination of the level of the update factor.

The first recommendation reflects the Commission's overall judgment of the appropriate level of the update factor for fiscal year 1986. The Commission believes its responsibility under the statute is to be as specific as possible in making its recommendation on this factor. The recommendation would require estimates for the hospital market basket and for "real" case-mix change to be developed by the Secretary. The Commission is recommending a specific amount for the remaining components of the "discretionary adjustment factor" which, in addition, to the market basket increase, would comprise the update factor.

The actual percentage change in the average payment per DRG for fiscal year 1986 may differ from the update factor. The update factor is applied to the standardized amounts, but the overall increase would also be affected by across-the-board adjustments to the DRG weights. The Commission proposes adjusting the DRG weights to remove the effects of any reported case-mix change that will have occurred during fiscal year 1985 so that changes in coding occurring this year would not be built into future PPS payments (Recommendation 17).

In Recommendations 2 through 9, the Commission proposes changes in the hospital market basket, the component of the update factor that reflects inflation in the prices that hospitals pay for inputs. Inflation in prices of inputs, the goods and services that hospitals purchase and use in the provision of hospital care, is generally thought to be beyond the control of hospitals and therefore appropriate adjustments should be reflected on hospital payment amounts when such prices are predicted to increase from one year to the next. Detailed information pertaining to the market basket recommendations is in Technical Appendix B.

Recommendations 10 through 12 concern the discretionary adjustment factor, which is the portion of the update factor that reflects considerations other than the market basket of hospital input prices. The Commission decided that the DAF should be set to reflect goals for the attainment of productivity gains and for scientific and technological advancement. The Commission also identified a third consideration for the DAF, an allowance for "real" changes in the mix of Medicare inpatients (contrasted with changes that arise only from altered coding practices). The Commission selected a specific numerical adjustment for productivity and scientific and technological advancement in Recommendation 10 but proposes that the Secretary develop the allowance for real case-mix change in Recommendation 11. Recommendation 12 satisfies the Commission's statutory obligation to recommend an update factor for hospitals and distinct parts of hospitals excluded from PPS.

In concept, the discretionary adjustment to the update might be positive, zero, or negative depending on judgments regarding the relative importance of the components that comprise the DAF. The Commission's recommendations reflect its best collective judgment regarding a discretionary adjustment for fiscal year 1986. It should not be assumed that the Commission's recommendation in subsequent years will be for the same amount. Detailed information on the DAFs is in Technical Appendix B.

Recommendations 13 through 15 address the distributional concerns expressed above. The Commission selected the definition of hospital labor market areas and disproportionate share hospitals as two problem areas of PPS deserving immediate attention in the establishment of the fiscal year 1986 payment rates. This does not imply that other problem areas are not also of great importance, but the Commission believes that the distributional consequences of these two problems are sufficiently severe, and the potential for finding workable solutions is sufficiently high, that immediate attention is warranted. Detailed information on these distributional issues is in Technical Appendix B.

Recommendation 16 pertains to the issues of rebasing the standardized amounts. The Commission goes on record in favor of rebasing, but recognizes that doing so for the fiscal year 1986 rates would be inadvisable due to the lack of suitable data. It is expected that rebasing concerns, including the identification of suitable data and methods of calculation, and the development of policy options for establishing new levels of the standardized amounts, will receive considerable attention from the Commission during the coming year.

CLASSIFICATIONS AND WEIGHTING FACTORS

The Commission is required to ". . . consult with and make recommendations to the Secretary with respect to the need for adjustments [in classifications and weighting factors] . . . based on its evaluation of scientific evidence with respect to new practices, including the use of new technologies and treatment modalities." These adjustments refer to the system for ". . . classification of inpatient hospital discharges by diagnosis-related groups and a methodology for classifying specific hospital discharges within these groups," and to the assignment of ". . . an appropriate weighting factor [to each diagnosis-related group] which reflects the relative hospital resources used with respect to discharges classified within that group compared to discharges classified within other groups." The Secretary is required to ". . . adjust the classifications and weighting factors . . . for discharges in fiscal year 1986 and at least every four fiscal years thereafter, to reflect changes in treatment patterns, technology, and other factors which may change the relative use of hospital resources." The Congress has directed the Commission to make recommendations regarding the DRGs ". . . for such groups to reflect appropriate differences in resource consumption in delivering safe, efficacious, and cost-effect care."

Recommendation 17 concerns recalibration of the DRG weights with a data base that is newer, more complete, and more accurate than the 1981 data on which the current DRG weights are based. The Commission's recommendation reflects its belief that, because of potential inaccuracies in the data originally used to establish the DRG weights and changes in hospital practice patterns since 1981, a full recalibration for the 1986 rates is advisable.

Two important features of the Commission's treatment of recalibration are, first, that it includes a recommendation for normalizing DRG weights so that the average weight of all PPS discharges is the same as it was at the beginning of fiscal year 1985 and, second, that it includes a recommendation to adjust DRG weights across the board for any change in reported case mix occurring during fiscal year 1985. The reduction in DRG weights implied by this adjustment would be offset, in part, by the positive allowance for real case-mix change described above as part of the recommended update factor.

This recommendation does not imply, nor should it be inferred, that the Commission will propose a recalibration or normalization next year or any specific subsequent year, nor does it suggest that the Commission will recommend the same type of data or approach for recalibration in the future. Further information on recalibration and related adjustments is in Technical Appendix C.

Recommendations 18 through 20 pertain to specific weighting, classification, and assignment issues concerning three procedures: pacemaker implantation, cataract extraction and intraocular lens implantation, and precutaneous transluminal coronary angioplasty. Two additional procedures, bone marrow transplantation and treatment of infective endocarditis, were determined not to require in-depth analysis at this time, as indicated in Recommendation 21. Detailed information concerning pacemaker implantation (Recommendation 18) is in Technical Appendix D; information pertaining to Recommendations 19 through 21 is in Technical Appendix C.

The Commission may make additional recommendations concerning these issues in the future, if new information becomes available. Furthermore, the majority of DRG weighting, classification, and assignment issues undertaken for review by the Commission in its first year require additional data and analysis. A summary of the issues currently under review is provided in Chapter 4. The Commission will supplement this report with additional recommendations as appropriate.

THE CONTEXT FOR THESE RECOMMENDATIONS

The Commission firmly believes that adoption of these recommendations will result in substantial improvement in PPS and will maintain the essentially positive experience that implementation of PPS has achieved to date. Nevertheless, because these recommendations necessarily are made in a rapidly changing health care environment, both in Federal health policy and in the private health sector, the Commission is concerned that the context in which its decisions were made be recognized. Changes in this context may lead the Commission to reconsider some of its recommendations. Such changes will also influence the Commission's choices of issues to address in future reports.

The Commission's recommendations are made under the assumption that current law and its interpretation will remain in force during fiscal year 1986. The Commission decided early in its deliberations that it would not attempt to predict policy changes arising from actions of the Executive Branch or the Congress. Nevertheless, if important policy changes occur, the Commission may wish to reconsider some of its recommendations.

The Commission also recognizes that its recommendations are made at a time when hospitals are in either the first or second year of experience with PPS and only a fraction of their payments are based on Federal DRG payment rates. During its deliberations, the Commission has learned about several demonstrated and potential problems of PPS which, if not corrected, may result in unwarranted hardships for some hospitals and Medicare beneficiaries. The Commission has made specific recommendations concerning two of these problem areas and has committed its resources to the study of several others.

The Commission believes that, as the transition to a fully implemented prospective payment system proceeds, serious problems must be identified and corrected. The Commission considered the possibility of specifically proposing a delay in the transition to allow additional time for problem solving but did not do so because it did not wish to interfere with the momentum of PPS. Nevertheless, the Commission has asked its staff to continue the analysis of the effects of the transition. If problems exacerbated by the transition are sufficiently severe and not correctable by other policy measures, a recommendation for delay in the transition will be considered. Further information on the transition issue is in Technical Appendix B.

Finally, the Commission does not wish to imply, nor should it be inferred, that issues not addressed in its 21 recomendations are unimportant. The Commission recognizes that there are many other important issues deserving serious attention and has already scheduled several of these issues for analysis in coming months. Chapter 4 presents a summary of these issues.

RECOMMENDATIONS REGARDING THE UPDATE FACTOR

Recommendation 1: Amount of the Update Factor

For fiscal year 1986, the standardized amounts should be updated by the projected increase in the hospital market basket, minus one percentage point, plus an allowance for the estimated increase in real case-mix complexity during fiscal year 1985. The negative one percentage point is a combined adjustment of a positive allowance for scientific and technological advancement and a negative allowance for productivity improvement and hospital product change.

This recommendation reflects the Commission's collective judgment of the appropriate increase in the level of payment per Medicare discharge under PPS, assuming that the Commission's other concerns regarding the market basket component of the update factor, the DRG weighting factors, and the distribution of payments across PPS hospitals are also addressed in the fiscal year 1986 payment rates. Further, this recommendation is based on the premise that no net reductions of increases in average per case payments to hospitals will be effected through measures other than the update factor, such as reducing the indirect teaching adjustment, incorporating capital payment under PPS at a budget-saving level, adjusting for coding changes occurring before fiscal year 1985, or any other change in total payments per discharge under PPS.

The rationale for this recommendation is provided in the discussions accompanying Recommendations 2 through 16. The Secretary should estimate the projected increse in the hospital market basket and the increase in real case-mix complexity using the most current data available at the time the payment rates are determined. These estimates, combined with the one percentage point net reduction for scientific and technological advancement, productivity improvement, and hospital product change, would determine the increase in average payments per discharge under PPS for fiscal year 1986.

THE HOSPITAL MARKET BASKET

Recommendation 2: The Number of Market Baskets

For fiscal year 1986, a single basket should be continued for those hospitals under PPS. The Commission will undertake a study to determine the appropriateness of developing market basket measures that reflect variation in economic factors across hospitals. The use of multiple market baskets by region and classes of hospitals within regions will be examined. If the analysis indicates that multiple market baskets are appropriate, the study will also include an assessment of the date required for implementation.

The effects of inflation on a hospital or group of hospitals can differ from those measured by a single national hospital market basket for a number of reasons. First, increases in the prices of some items—most notably wages—vary across regions. Second, regional differences in price levels may effect the market basket weights, which represent the share of total hospital expenditures going to a component. Market basket weights may also differ if hospitals purchase different amounts of an input than the average (e.g., hospitals in colder climates may need to purchase more fuel). Finally, a single national market basket may not be an appropriate measure of inflation for hospitals that use a different mix of inputs than the average because they provide different services.

Since past analysis has shown that differences in hospital input price increases across regions and certain hospital types are not statistically significant, the Commission has decided not to recommend that separate market baskets be developed at this time. But because the analysis is limited, further study should be undertaken to evaluate the extent to which prospective payment rates might be affected if variation were allowed in market basket weights, or regional inflation rates. Examination of the possible overlap between the adjustment for area wage differences already included in PPS payments and the development of regional market baskets should be included. Future consideration of multiple market baskets will require a trade-off between the benefits of improvements in equity and the costs of increasing the complexity of the payment system.

Recommendation 3: Market Basket for Psychiatric, Rehabilitation, and Long-Term Care Hospitals

Separate market basket weights should be used for the group of psychiatric, rehabilitation, and long-term care hospitals and related distinct-part units that are exempt from PPS, but subject to the TEFRA rate of increase limitation. Separate market basket weights need not be developed for children's hospitals.

Due to the nature of the services they provide, the labor share of total expenses in psychiatric, rehabilitation, and long-term care hospitals is substantially higher than in other hospitals. To best reflect the effects of inflation, the market basket weights used to set the target rate of increase for these hospitals should take into account this differing use of inputs, and any others that may exist. Although children's hospitals are also exempt from PPS, the current market basket weights are more appropriate for this group, since the labor share of total expenses in these hospitals is very close to the overall average on which the current weights are based.

Recommendation 4: Market Basket Wage Component—Occupational Groups

The wage component of the market basket should be split into three categories, each with separate weights: Managers and Administrators, Professionals and Technicians, and Other Hospital Workers. Changes in wages for these categories should be measured as follows:

Managers and Administrators: the Employment Cost Index (ECI) for Managers and Administrators.

Professionals and Technicians: a 50–50 blend of the Average Hourly Earnings (AHE) for the hospital industry and the ECI for Professionals and Technicians.

Other Hospital Workers: a 50–50 blend of the AHE for the hospital industry and the ECI for all private industry.

(The discussion for all three of the Commission's recommendations regarding the treatment of wages in the hospital market basket follows Recommendation 6.)

Recommendation 5: Employment Cost Index Feasibility Study

For the long run, the Secretary should work with the Bureau of Labor Statistics to study the advantages and feasibility of developing an Employment Cost Index for the hospital industry that includes both public and private hospitals and covers increases in both wages and fringe benefits.

Recommendations 6: Study Effects of Changes in the Minimum Wage Law on Hospital Workers

The Commission plans to study the extent to which hospital workers would be affected by changes in the Federal minimum wage law. The intent of the study is to detect whether, under PPS, workers who earn more than the minimum wage are differentially affected by statutory increases in the minimum wage compared with workers in other industries. If a differential effect is found to exist, the Commission will consider requesting the Secretary to take appropriate action.

Wages are the largest single component of the hospital market basket, accounting for nearly 60 percent of hospital expenses. Currently, HCFA measures changes in all hospital wages by the AHE in the hospital industry, a data series collected by the Bureau of Labor Statistics.

Recommendations 4 through 6 address two major problems with the current treatment of wages in the market basket. First, the AHE series does not separate changes in inflation from changes in the skill mix of workers in the hospital industry. As a result, some portion of the growth in the series over time has probably been due to shifts in the type and use of hospital employees (e.g., substitution of RNs for LPNs).

Creating separate wage categories by occupational groups as the Commission recommends would take account of broad changes in skill mix among managers, professionals, and other hospital workers. Weights for the recommended categories could be developed using 1980 Census data. In addition, differences in wage growth among these groups would also be addressed. In particular, a separate measure of wage change would be included for managers and administrators, who are excluded from the AHE series currently used.

The second major problem addressed by the recommendations is that use of a price change measure specific to the hospital industry allows hospital behavior—including the response to PPS incentives—to influence the increase in the market basket. Since the AHE series has risen in the past at a relatively high rate compared with other industries, there has been concern that exclusive use of a hospital industry series would allow hospitals to increase wages faster than other industries even when a differential was not warranted. More recently, however, growth in the AHE hospital series has slowed more rapidly relative to wages in other industries. If hospital wage growth is slowed in response to PPS incentives for cost containment, the market basket forecasts will reflect this, and hospital workers could be limited to wage increases lower than that of other workers.

Blending the AHE with the ECI, which includes workers outside the hospital industry, would mitigate these effects, yet still partially reflect any unique circumstances in the labor markets for hospital employees. To the extent that the hospital labor market is unique, exclusive use of the ECI or other broader industry measures might fail to adequately portray the economic forces beyond the control of hospitals.

For the long run, an ECI should be developed for the hospital industry. Although it would not be used to replace the ECI measures recommended above, a hospital industry ECI might be preferred to the AHE series since the ECI measures skill-mix differences and hourly wages directly. If developed, this series could be used to measure changes in hospital industry wages and may or may not be used in the market basket.

Recommendation 7: Correction of Market Basket Forecast Errors

The update factor should include a correction for substantial errors made in the previous year's forecast of changes in the external price measures used in the hospital market basket. In the judgment of the Commission, substantial errors are those that equal or exceed 0.25 percentage points (or, when rounded in the published forecasts, 0.3 percentage points). The Commission will undertake a study to determine the extent to which differences between forecasted and actual increases in the internal price change measures are due to factors beyond the hospitals' control. Substantial errors determined after study to be due to factors beyond the hospitals' control should be corrected in the update factor.

(The discussion for both the Commission's recommendations regarding correction of market basket errors follows Recommendation 8.)

Recommendation 8: Statutory Change for Forecast Error Correction

The Secretary has determined that she does not have the statutory authority to correct for market basket forecast errors. Therefore, the Secretary should seek statutory change to provide explicitly that the update factor include a correction for errors in forecasting the market basket beginning in fiscal year 1986.

Regardless of the method of forecasting inflation in the hospital market basket, errors are bound to occur that might have sutstantial financial consequences for hospitals or the Federal government. A correction need not be made, however, when the forecast error is small, since both the Federal government and hospitals should be able to manage within a margin of error. The prospective nature of payment rates is not compromised when the correction is made by adjusting the increase in the following year's rates.

The recommendation, however, distinguishes between internal and external price change measures (or price proxies). External proxies are those that measure price changes that extend beyond the hospital industry. For example, inflation in food prices is measured in the hospital market basket be a combination of food components of the Consumer Price Index and the Producer Price Index. Changes in these measures are beyond the control of the hospital industry, and therefore differences between actual and forecasted changes in the price proxy can be attributed to forecast error alone. Alternatively, internal proxies are those that apply solely to the hospital industry (e.g., wages as measured by the AHE series for the hospital industry). In this case, behavior of the hospital industry affects the actual increase in the price proxy. If the difference between forecasted and actual increases in internal proxies were automatically adjusted, hospital incentives to limit price increases in those categories would be reduced. Until further study can distinguish between the effects of forecast error and hospital behavior, no correction should be made for the differences between forecasted and actual changes in internal price proxies.

The Secretary has interpreted the statute to prohibit an adjustment for correcting market basket forecast errors. Because of this, the statute should be clarified by the Congress to explicitly require correction of forecast errors in the update factor.

Recommendation 9: Rebasing of Market Basket Weights

Market basket weights should be rebased at least every five years. Rebasing should be preformed more frequently if significant changes in the weights occur. In addition, the market basket weights will need to be rebased if payment for capital or direct medical education is included in the PPS rates.

The current HCFA staff plan to update market basket weights every five years seems reasonable, but more frequent rebasing might be necessary if hospitals change—perhaps in response to the PPS—the mix of inputs they use to provide services. In addition, if policy changes are made to include capital or direct medical education costs in the overall PPS rates, the market basket weights will need to be recalculated.

DISCRETIONARY ADJUSTMENT FACTOR

Recommendation 10: Allowance for Productivity and Scientific and Technological Advancement Goals

For the fiscal year 1986 payment rates, the allowance in the discretionary adjustment factor for scientific and technological advancement, productivity improvement, and hospital product change should be set at minus one percentage point.

The discretionary adjustment factor (DAF) is based on a policy decision regarding the rate at which the Medicare standardized amount should change beyond increases in the hospital market basket. For the fiscal year 1986, the Commission has included in the DAF three broad allowances: one for technological and scientific advances; one for productivity; and one for changes in the hospital product. An additional allowance for real case-mix change should also be added by the Secretary. In future years, the Commission may choose to expand the elements in the DAF to reflect other factors.

This recommendation addresses the quantitative allowance for productivity, product change, and technological and scientific advances. The fiscal year 1986 adjustment for real case-mix change is addressed in Recommendation 11 and its accompanying discussion.

The update factor should encourage hospitals to seek productivity gains while, at the same time, ensure that sufficient funds are available to finance the adoption of quality-enhancing technologies after balancing the medical benefits against the costs of such technologies. Together, these allowances in the DAF constitute a judgment about how much of the desired growth in technology can be funded out of productivity gains or other resources already in the payment system.

In developing quantitative allowances for this portion of the DAF, the Commission was required to make implicit judgments for which there is little precedence. Moreover, the technical methods and data available upon which to base these judgments yield imprecise estimates.

The Commission's recommendation for the DAF reflects the following broad guidelines:

Adjustments	*Percentage Allowance*
Scientific And Technological Advances	+1.5 to +2.0
Hospital Productivity	−1.5 to −2.0
Changes In The Hospital Product	−1.0
Net Adjustment (Before Inclusion Of the Allowance for Real Case-Mix Change)	−1.0

By recommending a small negative aggregate allowance for these elements of the DAF in fiscal year 1986, the Commission does not imply that there should be no allowance for technological growth. Rather, it is reasonable to expect that, at least for one year, any requirements for new technology can be funded from potential gains in productivity and changes in the types of services produced in an inpatient setting. Moreover, the DAF allowance is not the only method to finance technology adoption. In particular, the capital costs associated with new technologies are currently reimbursed on a retrospective cost basis under PPS.

The adjustment for technology reflects the Commission's view that the hospital industry will not continue to experience the same rate of growth as in the past decade. Future expenditures should reflect a balance between long-term growth in the hospital industry and growth in the remainder of the enconomy.

In the hospital industry, productivity is difficult to measure due to problems in defining an appropriate output or product. In the simplest terms, the hospital product under PPS is a discharge, as classified and labeled by the DRG system. The Medicare PPS provides significant incentives to change the nature of this product, including incentives to shift services from an inpatient to an outpatient setting or to move patients out of the hospital more quickly. As a result, the output previously produced during an inpatient stay can be produced by using a mix of inpatient and outpatient services.

It is difficult to separate changes in the hospital product from changes in productivity. The potential for productivity gains was examined from a variety of perspectives. These included analyses of staffing patterns and changes in average length of stay as well as the development of a specific productivity target for the industry. Based on these analyses, the Commission adopted an overall productivity guideline between minus 1.5 and minus 2.0 percent.

Changes in the hospital product can result from a shift of services from inpatient to other care settings. This shift would reduce the cost to the hospital of DRG production without necessarily achieving any reduction in total costs. Under these circumstances, the Medicare program could be overpaying for services since the cost base for the DRG rates includes the costs of services that have subsequently been removed from the inpatient setting.

Quantitative evidence regarding changes in the hospital product is limited to changes in average length of stay. Changes in length of stay, however, reflect both changes in productivity and changes in the hospital product. The most recent data available from the American Hospital Association's Panel Survey indicate a 7.8 percent decline in length of stay for patients 65 years of age and older in the first nine months of 1984 compared with the same period in 1983. Although it cannot be assumed that all of this change is related to PPS, the declines in length of stay are consistent with the incentives established by the Federal cost containment initiatives under TEFRA and PPS.

While the shorter lengths of stay cannot be directly or immediately translated into a 7.8 percent reduction in costs, the Commission believes that for fiscal year 1986 such a decline would result in at least a 3.7 percent reduction in costs due to productivity gains and a 1 percent reduction due to changes in the hospital product. In order to continue sharing gains from improved efficiency, approximately half of the productivity cost savings should be retained by the hospital industry. In addition to providing support for investment in new technology and services, these funds would be available to develop hospital programs to assist patients who may have difficulty gaining access to care, and to help displaced hospital employees locate other employment or vocational retraining.

The recommendation for the DAF is based on the assumption that the Commission's other recommendations in this report are implemented. Taken together, these recommendations are intended to ensure that the Medicare program continues to pay a reasonable price for inpatient hospital services. The Commission is concerned that, while an update factor significantly less than the historical amounts is adequate on the average, it may be inadequate for certain types of hospitals and the

Medicare beneficiaries they serve. This concern is evidenced in the Commission's recommendations regarding disproportionate share hospitals and hospital labor market areas (Recommendations 13 through 15). Implementation of these recommendations will materially affect the maintenance of equity under increasingly constrained PPS expenditures.

Further, the Commission made this recommendation under the explicit assumption that no adjustments affecting the level of average PPS payments per case would be made other than those it recommended.

The Commission believes the recommended level of the DAF adequately meets the costs of treating Medicare patients. It is not appropriate or expected that hospitals use other sources of revenue to absorb the costs of treating Medicare patients (e.g., raising charges to other payers or using reserve funds). To expect other sources to fund Medicare patients is an inappropriate policy that eventually would compromise the access of Medicare beneficiaries to quality care.

Recommendation 11: Adjustment for Case-Mix Change

Prospective payments to individual hospitals and in the aggregate should reflect real changes in case mix. Changes in reported case mix that are unrelated to actual differences in the types of patients treated should not be built into future PPS payments.

Over time, changes in the distribution of patients across DRGs would be expected to increase the average PPS discharge weight for two reasons. First, real changes in the types of Medicare admissions may occur due to shifts in patterns of service delivery, the aging of the population, or other factors. In particular, the mix of hospital inpatients across DRGs may become more complex as patients with less complicated diagnoses are more often treated on an ambulatory basis. For the same reason, the mix of patients within DRGs might also become more complex, although this would not be reflected in the average payment per discharge. Prospective payment should include compensation for these types of case-mix change, which are due to changes in patient characteristics.

Second, the average PPS discharge weight might increase as hospitals code a higher proportion of patients into more complex DRGs. This would be expected particularly in the initial years of PPS, since hospitals now have incentive to improve the completeness and accuracy of the diagnostic information reported on Medicare bills. This type of case-mix change should not be built into PPS payment amounts because changes in coding practices do not reflect an increase in the resources required to treat patients.

Since PPS payments automatically reflect all changes in reported case mix as they occur, an adjustment is necessary periodically to pay only for real case-mix change. The adjustment should also include an allowance for the overall increasing complexity in the mix of patients within DRGs.

For fiscal year 1986, the Commission recommends that, through recalibration, normalization, and adjustment of the DRG weights as described in Recommendation 17, the effects of case-mix change occurring in fiscal year 1985 should be removed from the DRG weights so that changes in coding would not be built into future PPS payments. Along with this, an adjustment for case-mix change occurring during fiscal year 1985 estimated to be caused by real shifts in the mix of patients should be included in the update factor. If adopted, the combined effect of these recommendations would be to allow PPS per-discharge payments to rise as a result of increasing complexity in the Medicare cases hospitals treat, if such increases occur, but not as a result of past changes in coding.

In determining the adjustment for real case-mix change, the Secretary should analyze the most recent data available when the fiscal year 1986 payment rates are set. The Commission will review the findings of this analysis when they are available, and may recommend a specific adjustment at that time.

Recommendation 12: Update Factor for Exempt Hospitals

In addition to the projected increase in the market basket, hospitals and hospital distinct-part units exempt from PPS should receive a minus one percentage point adjustment in their fiscal year 1986 update factor for productivity improvement and scentific and technological advancement.

In addition to a full alllowance for inflation, the Commission has emphasized that the update factor should incorporate policy goals for productivity and scientific and technological advancement. These concepts are as difficult to quantify with precision for exempt hospitals and distinct part units as they are for hospitals included in PPS. Nevertheless, the Commission believes that the update factor for both sets of hospitals should include an adjustment for these elements.

The Commission recognizes that differences exist between PPS hospitals and exempt hospitals and units, as illustrated in the recommendation for different market basket weights related to different mixes of inputs. It is possible that these hospitals differ from PPS hospitals in the ways that would suggest differing allowances for productivity and scientific and technological advancement Date are not currently available however, to sustantiate such differences.

Moreover, unlike PPS hospitals, exempt hospitals currently are not paid on a case-mix adjusted basis, and would not be subject to an adjustment for observed coding change in the recalibration process. Therefore, the Commission recommends that a minus one percentage point adjustment be adopted for exempt hospitals, with no additional adjustments for case-mix change. A separate update factor for exempt hospitals and units may be considered in the future.

Studies are being considered or conducted to gather and evaluate data specific to exempt hospitals to determine whether they can be phased into PPS, or if their specific products and processes cannot be fairly dealt with under PPS. Information from these studies will provide guidance upon which to base recommendations in future years regarding the appropriateness of a separate adjustment for different kinds of hospitals.

HOSPITAL LABOR MARKET AREAS—AREA WAGE INDEX

Recommendation 13: Improvement of Labor Market Area Definitions

In order to better reflect hospital labor markets, the Secretary should improve, as soon as possible, the current definition of a hospital labor market area used to adjust PPS rates for area wage differences, taking into account variations in wages paid in the inner city compared with suburban areas within a metropolitan area, and variations paid in different rural locations within a state. Implementation of this recommendation should not result in any change in aggregate payments.

The current wage index used to adjust payments for inter-area wage differences does not distinguish separate labor markets within Metropolitan Statistical Areas (MSAs). This inadequacy raises serious equity concerns. Several studies have shown that there is substantial variation in the wages paid in inner city as compared with suburban areas within the same MSA. Similar concern has been expressed regarding rural areas within a state. If PPS payments are to adjust for actual variations in area wage levels, the differences in hospital labor markets need to be reflected in the application of the area wage index.

The greatest difficulty faced in implementing the Commission's recommendation will be drawing the boundaries delineating hospital labor market areas. This is in part a problem generic to defining any labor market. The appropriate boundary definition is highly dependent on how the wage index is to be used. For the purposes of PPS, the boundaries for a hospital labor market area should be drawn so that the impact of the behavior of any single hospital on the wage index used to adjust that hospital's payment would be negligible. In small MSAs, there may be too few hospitals to designate more refined market areas. Thus, while it might be desirable to develop separate core and ring designations for each MSA and more refined designations for rural areas within states, it may not be possible to do so in every area.

The Commission clearly recognizes that there are substantial difficulties in developing new area wage indexes based on revised market areas. Nevertheless, the Commission believes the payment inequities engendered by the current system are sufficiently severe to warrant immediate correction. HCFA has better data on hospital labor markets than ever before, and the Secretary plans to revise the index for fiscal year 1986. To ensure the stability and predictability of PPS rates for hospitals in the future, it would be highly desirable to revise the wage index only once during this period. Thus, the Commission urges the Secretary to implement this recommendation in conjunction with any other revisions planned for the area wage index.

DISPROPORTIONATE SHARE HOSPITALS

Recommendation 14: Disproportionate Share Adjustment for Fiscal Year 1986

The Secretary should develop a methodology for adjusting PPS rates for disproportionate share hospitals and implement the adjustment in fiscal year 1986. The adjustment should be implemented so that it does not change aggregate payments.

The Congress has clearly stated its concern that specific adjustments should be made for hospitals incurring higher Medicare costs per case associated with treating a high proportion of low income or Medicare Part A patients if such costs are not already accounted for in the PPS methodology.

According to both the House Ways and Means Committee and the Senate Finance Committee Reports that accompanied the Social Security Amendments, the disproportionate share provision reflected congressional concern that "public and other hospitals that serve a large number of low income and Part A Medicare beneficiaries" may serve patients "more severely ill than average and that the DRG payment system may not adequately take into account such factors."

The Commission, having reviewed a number of studies, is convinced that hospitals serving a high volume of low income patients (as measured by a variety of definitions) do incur higher Medicare costs per case. For example, these studies (including those conducted by HCFA) indicate that there is a consistent and significant positive relationship between Medicaid volume and Medicare costs per case.

The precise reasons for these higher costs are unknown. Based on its studies, however, the Commission is also convinced that these higher costs per case are substantially due to factors beyond the control of these hospitals. Therefore, the Commission believes that a specific adjustment for these hospitals should be made in the fiscal year 1986 payment rates.

Development of a specific adjustment will require a reasonable definition of "disproportionate share." (Definitional problems are discussed under Recommendation 15).

To develop an appropriate adjustment, it will be necessary to separate the effects of serving a low income population from other factors already reflected in the current PPS rates. The indirect teaching adjustment, for example, may adequately compensate some hospitals for the additional costs of serving a disproportionate share of low income patients over and above the indirect costs of having interns and residents on the premises. If the indirect teaching adjustments were reduced on the grounds that the indirect costs of teaching are actually lower than the adjustment provides for, this would have the effect of undercompensating some teaching hospitals which serve a disproportionate share of low income patients.

Similarly, part—but not all—of the undercompensation of some disproportionate share hospitals is attributable to the current methodology used to define labor market areas. If this problem were ameliorated, as the Commission recommends in Recommendation 13, it would reduce but not eliminate the extent of this undercompensation. In addition, to the extent that disporportionate share hospitals incur higher costs related to a mix of patients more severely ill than average, improvements in case mix measurement may subsequently alter the disproportionate share adjustment necessary for these hospitals.

Because of these interactions, calculation of the disproportionate share adjustment should take into account the calculation of other adjustments in order to achieve the appropriate levels and distributions of payments to all hospitals.

The Commission recognizes that determining the magnitude of a disproportionate share adjustment will not be a simple task. It will require careful analysis of the interactions among hospital characteristics to ensure that hospitals are not over- or undercompensated by the mix of adjustments chosen. Given the work already conducted by HCFA on this issue, the Commission believes that a reasonable adjustment is feasible for incorporation in the fiscal year 1986 rates.

In the development of a disproportionate share adjustment, the Secretary should explore the feasibility of a graduated schedule of adjustments (with perhaps a minimum threshold, below which no adjustment would be made), rather than a single adjustment for hospitals that are above a single cutoff point. Such a schedule is likely to be far more equitable than a single adjustment which may provide windfall gains for those just above the cutoff point and unfair losses to those just below that point. California, for example, uses a graduated schedule as a part of its implementation of the Medicaid disproportionate share provision for its noncontracting hospitals.

Recommendation 15: Definition of Disproportionate Share Hospitals

The Secretary should complete the development of a definition of disproportionate share hospitals in ample time to include adjustments for these hospitals in the fiscal year 1986 PPS payment rates. The Secretary should consider broader definitions of low income than simply the percentage of patients who are Medicaid recipients and should determine whether the share of Medicare Part A patients should be excluded from the definition.

No adjustment to PPS rates for disproportionate share hospitals can be specified and implemented until a reasonable definition of disproportionate share is developed. The Deficit Reduction Act of 1984 requires the Secretary to develop and publish a definition of disproportionate share hospital and to provide Congress with a list of hospitals which meet this definition. As of late March 1985, the results of the Secretary's study had not been made public.

The Commission clearly recognizes the difficulty in defining disproportionate share hospitals. Problems arise in both the identification of a proxy measure for low income patients and in the relevance of including Medicare Part A patients in that definition.

The majority of studies to date indicate that the volume of Medicaid patients is positively associated with Medicare costs per case. Thus, Medicaid volume has been suggested as a reasonable proxy for low income. Medicaid eligibility criteria, however, vary considerably among the states and regions of the country. Consequently, the proportion of Medicaid patients may not be a consistent measure of low income patients. If the percent of Medicaid patients were used as a proxy measure of low income, then the Commission would urge that this measure be adjusted to reflect variations in state Medicaid eligibility requirements and variations in income levels across states.

The relevance of including Medicare patients in the definition of disproportionate share is questionable if the disproportionate share adjustment is to reflect higher Medicare costs per case associated with serving a given population. First, Medicare patients tend to be evenly distributed among types of hospitals. Second, almost all the studies to date have found no evidence that a higher proportion of Medicare patients contributes to higher costs per case when PPS variables are controlled. A recent American Hospital Association study, however, brings this conclusion into question.

According to this study, higher Medicare costs per case are associated with hospitals having a higher percentage of Medicare revenues or patient days. The findings for Medicare admissions, however, were inconsistent for the two years studied (1980 and 1981). In 1980, the study found that the greater the proportion of a hospital's admissions which were Medicare, the higher the Medicare costs per case. In 1981, a higher proportion of Medicare admissions was not found to be significantly associated with higher Medicare costs per case.

The Commission concludes that a number of key issues concerning the definition of disproportionate share hospital have not been settled. Therefore, the Commission urges the Secretary to perform the necessary analyses to resolve these issues as expeditiously as possible so that an equitable adjustment for disproportionate share hospitals can be developed.

REBASING THE STANDARDIZED AMOUNTS

Recommendation 16: Rebasing the Standardized Amounts

The standardized amounts used to determine hospital payments under PPS should be recalculated using cost data that reflect hospital behavior under PPS. The results of such a recalculation, with appropriate modifications, could be used to rebase the standardized amounts. Although recent cost data are not available to recalculate the standardized amounts for the fiscal year 1986 payment rates, the Secretary should implement a process for timely collection of the cost data necessary for future recalculation. The Commission will later consider more specific recommendations regarding the timing, data sources, and process for rebasing the standardized amounts.

Periodic rebasing of the PPS standardized amounts—that is, use of more recent data to recalculate the average cost per case that, after adjustment and updating, is multiplied by the DRG weight to determine payment for a Medicare discharge—would maintain a relationship between hospital costs and PPS payments that might be eroded by indefinite use of an update factor alone. Under rebasing, payment rates would automatically reflect changes in length of stay, shifts to outpatient services, and the number and types of ancillary services and technologies used to treat hospital inpatients. Taking these changes into account using an update factor alone would require estimating their effects with very limited information.

Rebasing the fiscal year 1986 standardized amounts is not recommended since the most recent cost data available (from fiscal year 1982) are only one year more recent than the data used to set the current rates. Therefore, these data would not yet reflect hospital response to the cost-reducing incentives present under PPS or even under the TEFRA reimbursement limits.

Rebasing requires making specific decisions regarding the data sources used, possible adjustments—including sharing of savings between providers and the program—and the frequency and timing of rebasing. The Commission will consider these issues in the future.

Data Used to Rebase the Standardized Amounts.—Timing of at least the first rebasing of the standardized amounts would be affected by the availability of data. Currently, the standardized amounts are calculated based on data included in the 1981 Medicare cost reports. Because of the lag in submitting and reviewing the cost reports, data from settled cost reports from the first year of PPS will probably not be available until 1987. Rebasing might be possible before then (perhaps for the fiscal year 1987 payment rates) by using cost reports as submitted or final reports from a sample of hospitals. The extent to which using data from a representative sample of hospitals might be a long-run way to implement periodic rebasing, yet still reduce the burden of cost reporting on the hospital industry, should also be considered.

Possible Adjustment to the Rebasing Calculation.—Rather than simply using the outcome of a recalculation of the standardized amounts, rebasing could involve recalculating the standardized amounts, and then applying an adjustment. In this way, the effects of rebasing on the payment rates—and ultimately on hospital revenue—could be limited and made more predictable. For example, the change in the standardized amounts resulting from rebasing could be limited to no more than 10 percent of the previous amount. The recalculated standardized amounts might be lower, reflecting hospital response to the cost-reducing incentives of PPS. On the other hand, the recalculated amounts might be higher, due to the restrictions of the budget neutrality provision in effect for the first two years of PPS or to stringent update factors after that.

Frequency and Timing of Rebasing.—Rebasing could be done annually, on a predetermined multiyear cycle (such as every four years) or on an ad-hoc basis. Annual rebasing would keep the relationship between payment rates and hospital costs as current as possible. It might be, however, that system changes would not occur rapidly enough to require annual repetition of the rebasing process. A carefully developed update factor might successfully predict trends in the hospital product and productivity, with rebasing necessary only over a longer period or when more dramatic changes occur. In addition, an argument often made against annual rebasing is that hospitals should share in productivity gains for some period before the gains are reduced by lower prices. Economic theory predicts that, even in a competitive market, there is lag time between the achievement of productivity gains and the market's automatic downward adjustment in prices. On the other hand, if costs were rising faster than payment amounts, more frequent rebasing would finance the increases with a short lag.

Short-run decisions about the frequency of rebasing could be made differently than long-run decisions. It may be reasonable to assume, for example, that the greatest changes in hospital behavior will occur in the initial years of PPS and that rebasing should be done more frequently in the early years than over the longer run.

Along with frequency, the timing of rebasing is also an issue to be considered. Once choice would be to rebase the standardized amounts whenever the DRG weights are recalculated. In this way, the whole system would be adjusted at once. Alternatively, rebasing might be done on a different schedule than recalibration so that system changes occur more gradually. In addition, rebasing would appropriate when other changes, such as the addition of capital to the PPS rates, are made in the system.

RECOMMENDATIONS REGARDING DRG CLASSIFICATIONS AND RELATIVE WEIGHTING FACTORS

Recommendation 17: Recalibrating the DRG Weights

For fiscal year 1986, all DRG weights should be recalibrated using the 1984 PATBILL data set. The newly recalibrated weights should be:

(1) Normalized so that the average case weight is the same as it was at the beginning of fiscal year 1985, thereby incorporating DRG weight adjustments made before the start of fiscal year 1985

(2) Adjusted for any demonstrable changes in reported case mix occuring during fiscal year 1985

Recalibration of the DRG weights is one way to adjust PPS payment periodically to reflect changes in hospital technologies and practice patterns that alter the relative resources used across DRGs to treat Medicare patients. Recalibration, which adjusts all DRG weights, should be contrasted with reweighting, which adjusts only certain DRG weights.

The original approach used to create the DRG weights (i.e., combining charge data from Medicare patient bills with cost information from the hospital's Medicare

Cost Report) would probably be preferred for recalibration this year as well, were it not for data lags. The most recent complete data base available for a 1986 recalibration using this methodology is the 1982 MEDPAR file of patient bill records and cost report data for the 1982 hospital accounting year—the year before TEFRA was implemented. These data are only one year more recent than the 1981 data used to establish the current weights, and would not reflect hospital response to cost-control incentives under PPS or even under TEFRA.

Rather than continuing to use older cost data or delaying recalibration until more recent cost data are available, the Commission recommends that recalibration be carried out for fiscal year 1986 using charge data from the Medicare PATBILL file for fiscal year 1984. This recommendation does not imply, nor should it be inferred, that the Commission will continue to recommend recalibration with charge data alone in the future.

DRG weights based on PATBILL data would offer two important advantages over the current DRG weights. First, the PATBILL file contains the most recent data available, including discharges for the first year of PPS. Second, the PATBILL file includes much more detailed diagnostic information than the 1981 MEDPAR file.

A possible disadvantage of using the PATBILL file alone is that it contains data on hospital charges, but not costs. Costs are generally thought to be more reflective of real resource use than charges, since charges can be distorted by hospitals' patterns of subsidization and revenue generation.

The Commission's analysis of the 1981 MEDPAR and Medicare Cost Report data indicates, however, that there is very little difference between weights constructed using the original methodology and weights constructed using charge data alone. Of the 358 DRGs for which weight can be constructed using Medicare data along, 327 DRGs (representing about 96 percent of discharges) have a weight difference of only between zero and 5 percent.

The Commission also recommends that, after the DRG weights are recalibrated, the new weights should be normalized so that the average weight of all PPS discharges is the same as it was at the beginning of fiscal year 1985. By normalizing in this way, the recalibration would affect only the distribution of payments across DRGs. It would not affect the overall average payment per discharge. A further adjustment to the weights should also be made for any demonstrable change in the average weight of a PPS discharge during fiscal year 1985. Such changes in reported case-mix could be estimated using the most recent fiscal year 1985 patient billing data available when the payment rates are set. If these steps are not taken, the average discharge weight—and therefore the average PPS payment—would change, in part due to shifts in the types of patients treated, and in part due to improvements in hospitals' diagnostic coding.

Adjusting to remove the effects of coding change during fiscal year 1985 from the DRG weights would not take away additional payments already received by hospitals, but it would prevent these coding changes from being built into future PPS payments.

Along with normalizing and adjusting the DRG weights, the Commission recommends that an adjustment reflecting shifts in the types of patients treated be included as part of the update factor for fiscal year 1986 (Recommendations 1 and 11). If these recommendations were adopted, payments would be allowed to rise as a result of increasing complexity in the Medicare cases hospitals treat, if such increases occur, but not as a result of past changes in coding.

The recommendation to recalibrate using charge data alone and to normalize and adjust the DRG weights is made specifically for fiscal year 1986. Concern has been raised that since hospitals have complete control over charges, they may be able to manipulate future charge-based recalibrations. Control of the DRG weights through charge-setting practices would be particularly possible for those DRGs common to only a few hospitals. This issue is not a concern for fiscal year 1986, since the 1984 charge data are already collected, but will be considered by the Commission in future recalibration decisions.

In upcoming reports, the Commission will address the frequency and timing of future recalibrations. This will be done as part of an analysis of long-run options for the development of a PPS data base and the timing of a number of system changes, including rebasing of the standardized amounts, overall reconstruction of the DRGs, and reweighting of individual DRGs as well as recalibration.

Recommendation 18: Cardiac Pacemaker Implantation

The DRGs involving cardiac pacemakers, DRGs 115, 116, 117, and 118, should be recalibrated in the same manner as other DRGs to reflect changes in practice since 1981. The Commission will continue to analyze diagnosis and procedure coding and

DRG classification related to pacemaker implantation and replacement; the distribution of costs and payments across discharges, hospitals, and DRGs; and the impact of PPS on the quality of patient care.

The Commission reviewed the appropriateness of Medicare hospital payments for pacemaker implantation. Problems in the 1981 MEDPAR and Cost Report files were identified that could have affected the weights for the pacemaker DRGs. With currently available data, however, it was impossible to estimate the magnitude and direction of these errors. Furthermore, many of the problems identified are not unique to pacemaker implantation and are likely to be corrected with changing hospital incentives under prospective payment.

Several methodologies were used to compare costs in the pacemaker DRGs with payments under PPS. On average, current payments appear to be as appropriate as for other DRGs. Recalibration of all the DRGs will adjust the pacemaker DRGs to reflect changing patterns of resource use related to advances in pacemaker technology (see Recommendation 17).

Several other issues concerning Medicare payments for pacemaker implantation require further evaluation in the future. There is a lack of specificity in the diagnosis and procedure coding for pacemaker recipients and in the grouping of the discharges into DRGs. The pacemaker DRGs have very high medical supply costs, which appear to be similar across all hospitals. However, since PPS adjust payments to reflect average cost differences among hospitals related to differences in location, area wage levels, and medical education, payment differences across institutions in the pacemaker DRGs may not correspond closely to cost differences. In addition, the financial incentives of PPS may lead some institutions to limit certain pacemaker-related services. If this occurs, quality of patient care could be adversely affected. Furthermore, hospitals may make decisions that lower the cost of care at the time of implantation but result in higher net costs for Medicare in the long-term care of the patient. The Commission plans to continue its analyses of these issues in the future.

Recommendation 19: Cataract Extraction and Intraocular Lens Implantation

DRG 39, Lens Procedures, should be recalibrated in the same manner as other DRGs to reflect changes in practice since 1981, including the more frequent implantation of an intraocular lens following cataract removal. The Commission will continue to monitor resource use in this DRG to determine whether the types of patients treated as hospital inpatients change with increased outpatient surgery for cataract removal.

Changes in practice patterns since 1981 were examined in cases assigned to DRG 39 because of the significant increase in the implantation of an intraocular lens (IOLs) following the removal of a cataract. Cataract extraction and/or IOL implantation represented 98 percent of the DRG 39 cases in the 1981 data used to construct DRG weights, but the data are insufficient to determine the percentage of these cases receiving intraocular lenses after removal of cataracts.

Other data indicate that the frequency of IOL implantation following cataract extraction has increased substantially. A national sample of hospital discharges indicated 58 percent of cataract extractions in patients 65 and over were accompanied by implanation of an IOL in 1981. This frequency increased to 85 percent in 1983.

Other changes in practice since 1981 that may have affected resource use for patients in DRG 39 are the increased use of posterior chamber lenses, sodium hyaluronate (Healon, a product used during surgery), and extracapsular rather than intracapsular surgery. Also, the length of hospital stays in DRG 39 decreased.

Since all of these pactice changes are likely to be reflected in the hosptial charges, the Commission recommends that the adjustments to the weight of DRG 39 be made in the process of overall recalibration (see Recommendation 17).

The Commission notes that future changes in practice resulting from the shift in cataract cases to outpatient settings may affect the type of patients treated as hospital inpatients. The Commission will monitor for evidence of this potential change.

Recommendation 20: Percutaneous Transluminal Coronary Angioplasty

Cases in which Percutaneous Transluminal Coronary Angioplasty (PTCA) is the principal procedure should be removed from DRG 108 and temporarily assigned to DRG 112 before recalibration. The Secretary should immediately implement a mechanism to identify bills for cases in which PTCA is performed in order to provide data for analysis and additional adjustments as appropriate.

PTCA is a new procedure that was not covered for Medicare beneficiaries when DRGs were created or when DRG weights were calculated. PTCA does not have a unique ICD-9-CM procedure code, so that cases in which PTCA was performed cannot be separated from cases involving other procedures given the same code. The procedure code used for PTCA is also used for removal of coronary artery obstruction by thoracotomy. As a result of this deficiency in procedure coding, cases in which PTCA is the principal procedure are assigned to DRG 108. This DRG, created for major surgical procedures that usually require significantly greater resources than PTCA, has a weight of 4.3756. Bills for inpatient hospital discharges during fiscal year 1984 show that PPS payments (excluding cost pass-throughs and indirect medical education payments) for DRG 108 were 155.5 percent of total charges for the services even though comparable PPS payments for all DRGs averaged 71.4 percent of total charges.

Reassignment of cases to alternative DRGs in the absence of complete information should be done only when available evidence indicates good cause for such action. The Commission considered leaving PTCA in DRG 108 until coding deficiencies could be corrected and cases could be identified for analysis of the resources consumed or moving it temporarily to a DRG that is more appropriate but reasonably clinically meaningful. DRG 112, Vascular Procedures except Major Reconstruction, with a weight of 2.3500 was selected based on the limited indirect evidence available concerning the costs of PTCA. This shift in the DRG assignment should be done before the recalibration for the fiscal year 1986 payments, so that the new weights for DRG 108 and DRG 112 will reflect the revised assignment.

The Commission is aware that PTCA is an alternative to coronary artery bypass graft surgery and that, in certain cases, PTCA is a cost-effective and preferred method of treatment. The recommendation to reassign PTCA from DRG 108 to DRG 112 is based on the Commission's analysis indicating that the original assignment was erroneous due to the deficiencies in procedure coding noted above. The temporary assignment of PTCA cases of DRG 112 results in more appropriate payment for the service, while maintaining the incentive to use this procedure when it is indicated for an individual patient. Further, reassigning PTCA will remove financial incentives that may have existed to perform PTCA when an alternative therapy, either medical or surgical, was preferable.

The Commissioner chose to recommend reassigning PTCA to a lower-weighted DRG because the original assignment was clearly erroneous. The Commission believes it is inappropriate to allow incorrectly categorized technologies to subsidize other types of cases or to allow other cases to subsidize incorrectly categorized technologies. The Commission also will not hesitate to recommend changes that increase payment for incorrectly categorized technologies when they are identified.

The Secretary should immediately implement a mechanism to identify PTCA, such as manual review of cases in which procedure code 36.0 is used. Once a sufficient number of PTCA cases have been identified, these data can be used to evaluate the resources consumed and to make additional adjustments as indicated.

Recommendation 21: No Change Recommended for Bone Marrow Transplantation and Infective Endocarditis

The Commission has examined Bone Marrow Transplantation and Treatment for Infective Endocarditis and is recommending no changes in DRG classification or weights at this time, other than those that would occur with recalibration. Information will continue to be gathered and the subjects reconsidered at an appropriate time.

Bone Marrow Transplantation is an established treatment for certain conditions. Experience with this technology is limited and is currently available in only a few centers in the U.S. Although patients over 65 years of age are not considered candidates for this procedure, Medicare patients eligible due to disability may be potential recipients. No specific procedure code exists for bone marrow transplantation. The procedure would currently be classified on the basis of patient diagnosis into DRGs where conventional treatment may require very different use of hospital resources. The Commission recommends that no action be taken on this issue at this time although it will be reevaluated as it becomes more widely adopted.

Infective Endocarditis was examined because of questions concerning the appropriateness of the reported geometric mean length of stay of DRG 126 and the generally recommended length of stay for treatment of this condition. When the differences between geometric and arithmetic averaging are considered the geometric mean lengths of stay do not appear to be inappropriate for this DRG. For this reason, as well as the relatively small number of Medicare patients hospitalized with infective endocarditis each year, the Commission recommends that no further action be taken on the issue of infective endocarditis at this time.

Chairman **Stark**. Thank you very much.

Let me take something that came to mind. The report you are going to do on the transition, are you going to consider just whether we should slow down or continue, or will you be considering alternatives? My concern is that to postpone is really to duck our responsibilities.

If the procedure is not right, my feeling is we ought to change it. If it is all right, we ought to let it go on as intended. And I hope that when you deal with that transition issue, you will rather than say it ought to be postponed, unless you really feel there is a tremendous amount of data lacking, but our experience legislatively has been when we start postponing something that is really the result. We just stop it.

And I am not sure I want to stop the transition from continuing unless there is a good reason or somebody can present a good case that that is the way it ought to be, not just wait and see.

Mr. Altman. I understand. And so does the Commission. It was the most hotly contested issue we faced all year. On every other recommendation, we had a unanimous vote from all 15 members of the Commission. In this area the vote was 8 to 7. It almost had some of the characteristics——

Chairman Stark. It has got a popularity like I enjoy.

Mr. Altman. I was thinking about the major issues you have to worry about here.

Now, I think what we are going to try to do is to provide you with more up-to-date information, you and your staff, on the impact of continuing the transition. But we fully recognize what you said. We noted in our report that we were conscious of the fact that if we delay the transition it could mean stopping it.

The concerns we have really center on the following—moving to national rates makes a lot of sense provided the problems in other areas that we have acknowledged or identified get solved. And we know what they are. They are very clear. They are also very hard to solve. And it deals with the issue of severity, disproportionate share, appropriate wage adjustments, the issue of the rural hospitals, and what to do with teaching hospitals.

Now, if all of those problems were solved tomorrow, the Commission would frankly support moving to national rates. The problem is if they are not solved, either because we do not know how to solve them or cannot agree, then moving to national rates could create tremendous hardships for certain sections of the country. And it is that issue we want to look at in a little more depth.

Chairman Stark. We will certainly appreciate that. The administration has recommended cuts in the indirect teaching adjustment. Do you have any feelings about that?

Mr. Altman. Well, as I indicated, again that is an area where if it was only the issue of the teaching hospital, I think at least my own statement would be more straight forward. But we have allowed the teaching adjustment to become a proxy for a variety of other problems such as severity of illness, disproportion share, urban, and so on.

And one of the things we have found is these problems are all interrelated. And therefore our recommendation says if there is a change in that teaching adjustment—we did not take a stand on whether there should be or not—any change should be built back into the base and should be accounted for in our overall increase.

In other words, that money shouldn't just be pulled out of the system. Because basically when the teaching hospitals got the multiplied adjustment in the first place it was pulled out of the other hospitals. So if you are going to reduce the teaching adjustment, you should put those savings back into the system.

You ought not, in our view, look at that as a budget item. It is really an equity issue. And you ought to focus in the budget issue on what the increase in the overall rate should look like.

There are some suggestions that the administration might plan to pull the indirect teaching savings out and not put it back into the system. And the Commission feels very strongly that is clearly appropriate to put it back into the system. But we have not taken a stand on whether the amount of twice the TEFRA rate is appropriate.

Chairman **Stark**. You have ventured into the area of wage indices, and you want to somehow reflect relative costs between the suburbs, the inner cities, and rural areas. I know McDonalds have tried that, and it does not work very well.

Are you sure you want to get into that? And will it make it any simpler for both of us in the long run?

Mr. **Altman**. Simpler we will not make it. Unfortunately I could assure you that we will complicate the issue. But we believe it is important to create a sense of equity. The problem we now have, as we see it, is that of using the large SMSA as a definition and allowing a big averaging process.

And there are significant differences in the wages paid by the inner city core hospitals that are forced to pay higher wages to attract individuals to work there, versus the hospitals in nice green suburban areas. We don't have any objections to these hospitals per se, but in a way they are getting a windfall.

And this is part of the problem in the disproportionate share issue as well as every other issue you are facing, because some of those hospitals in the inner city cannot meet their payroll. And so, while we recognize it is likely that we are going to come up with a recommendation that is more complicated, if you want the system to act fairly and equitably, I am afraid that is the natural outcome.

Chairman **Stark**. Mr. Gradison.

Mr. **Gradison**. Dr. Altman, I wonder if you could help me understand the relationship between the issue of intensity or severity and disproportionate share. If we adequately met the problem of intensity, would we then have met the problem of disproportionate share? And if not, why not?

Mr. **Altman**. I think we would go part of the way toward solving that problem. But it is likely that there still would remain a number of other factors which are not taken into account. We don't know how much of a problem would be left.

As I see the problem—and I would appreciate my colleague, Don Young to join in here too—as I see the problem, the hospitals that serve a disproportionate share of low-income patients face a number of problems that are not treated well by the big averaging that comes out of the DRG system, a big one of which is the severity of illness of the patients they treat.

But it also deals with the fact that these patients bring with them social problems and therefore are more difficult and expensive to treat. As I indicated there is also the problem of the wages, and we will never completely adjust for that problem.

There are also issues related to staffing patterns. And so I cannot tell you that if you solve the severity problem you have solved 82 percent or 56 percent. But I am fairly comfortable in saying that after you solve the severity problem, you will still have a disproportionate share problem.

Dr. **Young**. I agree entirely.

Mr. **Altman**. We are doing some work at Brandeis looking at social problems. And we have estimated on the ambulatory care side between 15 and 25 percent of the higher cost of inner city hospital-based ambulatory care is the direct result of the fact that they treat more patients with severe social problems as well as medical problems. And this treatment is expensive.

If someone comes in and has a drug problem in addition to having pneumonia, it may be impossible to send them home.

Mr. **Gradison**. With regard to the question of uncompensated care, it appears that the movement toward the use of DRG's and other similar pricing devices in non-Federal payment mechanisms is making it more difficult to shift the cost of uncompensated care to the paying patient.

To what extent does this relate to the problem? Do you think the Federal Government is sufficiently responsible in helping to intensify that difficulty of uncompensated care, that it should attempt to solve it by some kind of a mechanism of reimbursing institutions financed out of perhaps a tax on hospital bills nationwide? Or do you think we ought to continue the present circumstances which are basically to let each State work it out on its own?

Mr. **Altman**. First let me say the Commission itself did not focus on that issue, although I would venture to say most of the members feel very strongly that the uncompensated care issue is really the Achilles heel of our whole system and has to be dealt with.

I don't know what the best way to deal with it is, but I know it needs to be dealt with. And some States are grappling with that better than others.

I just came from New York, which is involved in a major debate about what it wants to do. The one issue that they say is clear is that they will come up with a proposal to deal with uncompensated care.

The State of Massachussetts has done it, and the State of Florida. Maybe that is the way to go—to allow States to deal with the uncompensated care problem.

I think if you do that you will still wind up with a significant number of States not doing anything. And I think that this is the most serious problem we face and could undermine the whole PPS system, which I basically believe is working well.

And one of the things I find uniformly—whether you are a liberal or conservative, whether you believe in State rights or Federal rights—the one area where there is uniform agreement is that in some way, through some mechanism, we have to deal with the uncompensated care problem or the whole system will fall out.

And I would personally like to see the Federal Government act in that scene even though it does not necessarily have to be the only actor. I would be willing to see States move too. What I am not comfortable with is nobody doing anything.

Mr. **Gradison**. Thank you, Dr. Altman.

Mr. **Altman**. Thank you, Mr. Chairman.

Chairman **Stark**. Stuart, thank you very much. As usual your thoughts are provocative and your statements enlightening. I appreciate your being here with us this morning and look forward to working with you on disproportionate share and many of the problems that face the subcommittee.

Mr. **Altman**. Thank you very much. This was a pleasure for me as well. We enjoy working with your committee and your staff. Thank you.

Chairman **Stark**. Thank you. All of you who have been so patient and cooperative, I asked again for relief in the form of chairs, but as yet I hear nothing.

If they arrive in the hall, if those of you who would like them would just quietly grab one and make all the first-row people second-row people, we will continue.

Our next panel is Ms. Phyllis Torda, health care specialist with the American Federation of State, County, and Municipal Employees, and Ms. Cathy Shoen, Service Employees International Union. She is the director of research.

I did agree to give Dr. Altman a great deal more time than the committee is able to give all of the panelists. We are going to attempt to limit witnesses to hopefully a 5-minute summary of prepared testimony which will appear in the record. The members of the committee will also make an attempt to hold their questions to 5 minutes.

And then if we are able to finish, and if there are any of the witnesses who feel an urgent need to discuss with us further, when we have heard all the witnesses, in fairness to those who have tried to make lunch plans or anything else, we will come back for a second round if anybody wishes that.

We do not have a timer here, but we have a diligent and accurate member of our staff who will wave a 1-minute sign in an attempt to keep witnesses to the 5 minutes.

And having said that, I would ask Ms. Torda to proceed to summarize or explain your prepared testimony in any manner you wish.

STATEMENT OF PHYLLIS TORDA, HEALTH CARE SPECIALIST, AMERICAN FEDERATION OF STATE, COUNTY & MUNICIPAL EMPLOYEES, AFL-CIO

Ms. **Torda**. Good morning, Mr. Chairman. My name is Phyllis Torda and I am the senior health policy specialist at the American Federation of State, County & Municipal Employees.

AFSCME represents over 1 million public and nonprofit workers in this country, including 300,000 health care workers.

Mr. Chairman, the AFSCME members who deliver public health services are witnessing a serious threat to the Nation's health. Since 1981 DC General Hospital has experienced a 400-percent increase in patient transfers. Senior citizens now pay as great a percentage of their income for health care, 15 percent, than they were before the Medicare Program was enacted in 1965. Meanwhile, the for-profit health sector continues to expand its capital expenditures and return on equity subsidized by the Federal Government.

All of these developments are directly attributable to the policies of the Reagan administration with regard to the public provision and financing of health care. The administration's proposed Medicare budget cuts for fiscal year 1986 will exacerbate these alarming trends.

Medicare beneficiaries with a median annual income of less than $7,000 are asked to bear 31 percent of the administration's proposed budget cuts. Public hospitals, many of which are teaching hospitals, would be denied half of their current teaching adjustment even though those funds were added to make up for serious projected losses under prospective payment.

The Reagan administration has bestowed upon the elderly and disabled citizens dependent upon Medicare services the dubious distinction of being the target of the second largest cut behind general revenue sharing in Federal spending.

Appended to this testimony is AFSCME's State-by-State analysis of the impact of previous and proposed Medicare budget cuts.

As of this fiscal year, the average Medicare beneficiary is already losing $200 a year in Medicare benefits due to previously enacted cuts. AFSCME encourages the committee to reject the notion that senior citizens should now pay more for their health care than they were in 1965.

Hospitals have responded to the incentives to economize built into the prospective payment system. The administration's response is to arbitrarily eliminate hospitals inflation allowance. Arbitrarily eliminating hospitals' inflation allowance will force hospitals to make equally arbitrary cutbacks.

The accounts of premature Medicare discharges such as those documented by the Government Accounting Office will certainly increase. Clamping down more on hospital operating costs makes no sense when capital costs are uncontrolled. Patient care and hospital workers are being sacrificed with the approval of the Federal Government in favor of unnecessary hospital construction and expensive duplicative technology.

We urge the committee to encourage true health care cost containment by enacting prospective payment for hospitals capital expenditures and eliminating Federal reimbursement for the return on equity.

AFSCME represents approximately 100,000 workers in public hospitals. Public hospitals stand to lose more under the administration's budget proposals than any other group of health care providers.

Public hospitals have a responsibility to treat everyone, including those patients turned away by other hospitals because their diagnoses are unprofitable to treat.

Recent research by the American Hospital Association, the Congressional Budget Office, the District of Columbia Hospital Association, the Urban Institute, Brandeis University, and the Health Care Financing Administration shows that hospitals treating disproportionate numbers of the poor have higher Medicare costs. This means that they will lose more and more money as DRG rates move toward a national average.

When the prospective payment system was enacted, Congress included three provisions designed to prevent a negative impact on hospitals treating large numbers of the poor. These provisions included the special adjustment for treating poor patients, the doubling of the adjustment for indirect teaching costs, and the request that the Department of Health and Human Services propose ways of refining the DRG methodology to better take into account severity of illness.

Now the administration proposes to take away the only one of those three provisions now in effect. Meanwhile public hospitals are experiencing record deficits. In Austin, TX, in Erie County, NY, and in Saint Paul, MN, communities are considering privatizing the public hospitals in which AFSCME members work. If these urban public hospitals are privatized, there will be a serious lack of decent care for the indigent including the unprofitable Medicare patients.

The administration for 3 years has denied that hospitals treating disproportionate numbers of the poor have higher costs. Now there are reports of an internal HHS document which alleges that indeed disproportionate share hospitals do have higher costs, but that these are due to management inefficiency, high labor costs, and a patient population that is more severely ill. In order to avoid spending funds for poor Medicare beneficiaries, HHS is resorting to spreading misconceptions about public hospitals.

Analysis by the Urban Institute and the American Hospital Association shows little difference between hospitals with deficits and those with surpluses in terms of efficiency characteristics. Public hospitals are disproportionately represented in the group of hospitals with deficits.

As far as labor costs go, public hospitals are by no means overly generous. The average entry level salaries of AFSCME members who work in hospitals are as follows: laundry operators, $11,442; housekeepers, $12,763; licensed practical nurses, $13,784.

We know that many members of this committee are aware of the administration's insensitivity to the problems of public hospitals. And we want to thank Congressmen Rostenkowski, Stark, and Rangel for communicating to Secretary Heckler their concern about HHS's lack of action on the disproportionate share adjustment.

It is essential that Congress act this year to ensure access of all U.S. citizens to decent health care. The indirect teaching adjustment should not be cut. Congress should support the Prospective Payment Advisory Commission by requiring a disproportionate share adjustment in time for the fiscal year 1986 rates.

[The prepared statement follows:]

Statement of Phyllis Torda, Senior Health Policy Specialist, American Federation of State, County & Municipal Employees, AFL-CIO

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Mr. Chairman, the AFSCME members who deliver public health services are witnessing a serious threat to the nation's health. Since 1981, D.C. General Hospital has experienced a 400% increase in patient transfers. Senior citizens now pay as great a percentage of their income for health care, 15 percent, as they were before the Medicare program was enacted in 1965. Meanwhile, the for-profit health sector continues to expand—its capital expenditures and return on equity subsidized by federal taxpayers.

All of these developments are directly attributable to the policies of the Reagan Administration with regard to the public provision and financing of health care. The Administration's proposed Medicare budget cuts for FY 1986 will exacerbate these alarming trends. Medicare beneficiaries, with a median annual income of less than $7,000, are asked to bear 31% of the Administration's proposed Medicare budget cuts. Hospitals, which have responded to the cost containment incentives of the prospective payment system exactly as the Administration hoped they would, are now being asked to treat Medicare patients without any cost of living increase. Public hospitals, many of which are teaching hospitals, would be denied half of their current teaching adjustment, even though those funds were added to make up for serious projected losses under prospective payment.

PROPOSED CUTS HURT BENEFICIARIES

The Reagan Administration has bestowed upon the elderly and disabled citizens dependent upon Medicare services the dubious distinction of being the target of the second largest cut, behind general revenue sharing, in federal spending. Appended to this testimony is AFSCME's state-by-state analysis of the impact of previous and proposed Medicare program cuts. As of this fiscal year, the average Medicare beneficiary is already losing $200 a year in Medicare benefits due to previously enacted cuts. AFSCME encourages the Committee to reject the notion that senior citizens should now be paying more for their health care than they were in 1965.

The Administration's proposals to freeze the fees paid to doctors and hospitals on behalf of Medicare beneficiaries will result in hardship for those beneficiaries. Freezing the fees paid to physicians will encourage fewer physicians to accept Medicare assignment. The fairest way to control the cost of Part B is to implement prospective payment for physicians as quickly as possible.

Hospitals have responded to the incentives to economize built into the prospective payment system. Hospital inflation is much closer to that of the general economy than previously; hospital length of stay for Medicare patients is down two days; hospital admissions decreased 2% from October 1983 through September 1984. The Administration's response is to arbitrarily eliminate hospitals' inflation allowance. Arbitrarily eliminating hospitals' inflation allowance will force hospitals to make equally arbitrary cutbacks. Accounts of premature Medicare discharges, such as those documented by the Government Accounting Office, will certainly increase.

Clamping down more on hospitals' operating costs makes no sense when capital costs are uncontrolled. Patient care and hospital workers are being sacrificed, with the approval of the Federal government, in favor of unnecessary hospital construction and expensive, duplicative technology. The Administration is flaunting the inequity of the situation by not producing the Congressionally mandated report. We urge the Committee to encourage true health care cost containment by enacting prospective payment for hospitals' capital expenditures and eliminating federal reimbursement for return on equity.

PUBLIC HOSPITALS IN CRISIS

AFSCME represents approximately 100,000 workers in public hospitals. Public hospitals stand to lose more under the Administration's budget proposals than any other group of health care providers. Public hospitals have a responsibility to treat everyone, including those patients turned away by other hospitals because their diagnoses are unprofitable to treat. Recent research by the American Hospital Association, the Congressional Budget Office, the District of Columbia Hospital Association, the Urban Institute, Brandeis University and the Health Care Financing Administration shows that hospitals treating disproportionate numbers of the poor have higher Medicare costs. This means that they will lose more and more money as the DRG rates move towards a national average.

When the prospective payment system was enacted, Congress included three provisions designed to prevent a negative impact on hospitals treating large numbers of the poor. These provisions included the special adjustment for hospitals treating disproportionate numbers of the poor, the doubling of the current adjustment for indirect teaching costs, and the request that the Department of Health and Human Services propose ways of refining the DRG methodology to take into account better severity of illness. Now, the Administraton proposes to take away the only one of those three provisions actually in effect.

Meanwhile, public hospitals are experiencing record deficits. In Austin, Texas, in Erie County, New York, and in St. Paul, Minnesota, communities are considering privatizing the public hospitals in which AFSCME members work. If these urban public hospitals are privatized, there will be a serious lack of decent care for the indigent, including the "unprofitable" Medicare patients. The resources of public hospitals are being strained intolerably. Doctors at D.C. General Hospital report, for example, that the 400% increase in patient transfers there has meant 6-hour waits in the emergency rooms, 4-hour delays in admitting, and acute shortages in the pharmacy.

DISPROPORTIONATE SHARE ADJUSTMENT ESSENTIAL FOR FISCAL YEAR 1986

For three years the Department of Health and Human Services has denied that hospitals treating disproportionate numbers of the poor have higher costs. The Department has ignored the December 31, 1984 deadline established by law for a report on which hospitals should qualify for a disproportionate share adjustment. Now there are reports of an internal HHS document which alleges that, indeed, disproportionate share hospitals do have higher costs, but that these are due to management inefficiency, high labor costs, and a patient population that is more severely ill.

In order to avoid spending funds for poor Medicare beneficiaries, HHS is resorting to spreading misconceptions about public hospitals. Analysis by the Urban Institute and the American Hospital Association shows little difference between hospitals with deficits and those with surpluses in terms of efficiency characteristics like staff-to-bed ratios, annual payroll per full-time employee, occupancy rates and hospital size. Public hospitals are disproportionately represented in the group of hospitals with deficits. A Brandeis University researcher has shown that public hospitals, faced for years with requirements for prospective budgeting, have set an example of learning to behave more efficiently while assuring equal access. Between 1970 and 1980 costs per admission grew most slowly in the public sector. As far as labor costs go, public hospitals are by no means overly generous. The average entry level salaries of AFSCME members who work in hospitals are as follows: Laundry operators, $11,442; housekeepers, $12,763; licensed practical nurses, $13,784; registered nurses, $16,590. There is no dispute that public hospitals must pay more than their suburban counterparts to attract workers. It may also be true that public hospitals need more staff to take care of the multiple needs of their patients.

We know that many members of this Committee are aware of the Administration's insensitivity to the problems of public hospitals and we want to thank Congressman Rostenkowski, Congressman Stark and Congressman Rangel for communicating to Secretary Heckler their concern about HHS' lack of action on the disproportionate share adjustment. It is essential that Congress act this year to ensure access of all U.S. citizens to decent health care by preventing further financial crises at public hospitals. The indirect teaching adjustment should not be cut. Congress should support the Prospective Payment Advisory Commission by requiring the Department of Health and Human Services to implement a disproportionate share adjustment in time for the FY'86 rates. Congress should also communicate to the Department that it is very serious about wanting a severity adjustment to the current DRG methodology.

When the budget comes to the House floor, members must also reject the Administration's proposal to cut back the Medicaid program, transforming it from an entitlement to a block grant. Public hospitals depend on Medicaid funding for approximately one-fourth of their revenues.

Mr. Chairman, we are also deeply concerned about proposals that would tax health care and other benefits provided to workers by their employers. AFSCME has worked long and hard to provide our members with excellent benefit packages. These various benefit programs protect public employees from medical and financial disaster. Taxing fringe benefits will jeopardize the possibility of negotiating benefit improvements and perhaps result in benefit reductions. We see no justification for increasing the tax burden of working people who are already paying more than their fair share of federal taxes.

We'd like to thank this Committee for its thorough examination of the Administration's health budget proposals. We hope that the Committee will agree with us that cutting back on publicly financed and provided health care is not an appropriate means of deficit reduction. Thank you.

STATE-BY-STATE ANALYSIS—MEDICARE BUDGET CUTS

[In millions of dollars]

State	Cumulative change in Federal aid [1]	Reagan administration budget [2]
Alabama	−189.63	−57.51
Alaska	−7.37	−2.22
Arizona	−136.24	−38.67
Arkansas	−116.43	−33.69
California	−1440.64	−412.09
Colorado	−116.71	−34.08
Connecticut	−169.35	−49.53
Delaware	−27.90	−8.02
District of Columbia	−50.30	−14.76
Florida	−835.82	−239.86
Georgia	−210.43	−61.53
Hawaii	−33.91	−9.67
Idaho	−32.91	−9.70
Illinois	−651.62	−198.25
Iowa	−257.60	−78.26
Indiana	−148.63	−45.19
Kansas	−138.72	−41.91
Kentucky	−151.20	−46.04
Lousiana	−158.60	−48.53
Maine	−61.02	−18.43
Maryland	−217.76	−64.70
Massachusetts	−391.07	−116.10
Michigan	−537.19	−156.66
Minnesota	−193.93	−58.30
Mississippi	−109.29	−32.84
Missouri	−298.01	−92.59
Montana	−33.38	−9.87
Nebraska	−76.47	−23.16
Nevada	−44.00	−12.84
New Hampshire	−42.29	−12.64
New Jersey	−432.36	−125.84
New Mexico	−49.79	−14.47
New York	−1100.95	−319.13
North Carolina	−224.63	−66.93
North Dakota	−36.71	−11.15
Ohio	−565.96	−170.79
Oklahoma	−150.51	−45.53
Oregon	−133.14	−40.06
Pennsylvania	−787.96	−233.39
Puerto Rico	−37.56	−10.53
Rhode Island	−61.24	−17.73
South Carolina	−109.77	−32.76
South Dakota	−34.57	−10.59
Tennessee	−207.82	−62.60
Texas	−640.99	−188.42
Utah	−38.33	−11.16
Vermont	−24.45	−7.38
Virginia	−210.71	−62.46
Washington	−164.37	−49.62
West Virginia	−94.12	−28.88
Wisconsin	−241.38	−73.39
Wyoming	−14.79	−4.50

[1] Cumulative change in Federal aid, fiscal year 1981 policy level through fiscal year 1985.

[2] Reagan administration budget, fiscal year 1986.

Source: "Broken Promises: A Report on the State of the Elderly During the Reagan Administration" and "State of the States," American Federation of State, County and Municipal Employees.

Chairman **Stark**. Ms. Torda, particularly in view of just waiting for that compliment that I knew you were going to pay the chairman and myself, I now must ask you if you would suspend and let Ms. Schoen speak now that we got to the meat of what your testimony was. We will get back to some questions in a moment.

I would ask Ms. Schoen if she would like to summarize or expand on her written testimony.

STATEMENT OF CATHY SCHOEN, DIRECTOR OF RESEARCH, SERVICE EMPLOYEES INTERNATIONAL UNION, AFL-CIO

Ms. **Schoen**. I am Cathy Schoen, research director of the Service Employees International Union. On behalf of our president, John Sweeney, and our 850,000 members nationwide, I thank you for the opportunity to testify today.

At the outset I want to make the point that the Medicare cuts, and budget cuts, are irrelevant to the Federal deficit. We urge you to help abolish the myth that by cutting Medicare we solve deficit problems.

Five out of seven Medicare dollars are obtained from a trust fund. By cutting the budget for Medicare, we merely create surpluses in the trust fund. These surpluses cannot be used for deficit reduction. In other words, the deficit remains the same.

It is time the American people were told that the cuts would not decrease the Federal deficit, that they will merely shift costs on to the elderly and push to the brink of bankruptcy any hospitals or physicians serving low income or Medicare beneficiaries.

The budget cut proposals are a betrayal of a national trust. Any civilized country takes care of its aging citizens, its disabled, sick, and children. Access to services is basic to the fabric of our society.

The Medicare and Medicaid Program combined have contributed to dramatic improvement in the life span of Americans. The proposed $44 billion cuts over the next 5 years would make 30 million senior citizens and disabled citizens pay more, impoverish several hundred thousand elderly and disabled citizens, and at the same time increase the cost to private employers and union trust funds.

We found from previous cuts that in one trust fund alone the shifting of Medicare costs contributed to a $5 to $7 million increase in our trust fund outlays. These proposed cuts make no sense.

Citizens are honoring their part in the trust by paying taxes. The President should do the same.

Today Medicare is paying for less than half of the health needs of retirees. Meanwhile payments to hospitals without regard to necessary costs of decent care is pushing those hospitals with commitment to serve people regardless of ability to pay to the brink of bankruptcy.

Our 300,000 hospital and nursing home workers nationwide are reporting across-the-board layoffs in virtually every hospital, that serves a disproportionate share of low-income patients and Medicare patients. They are also reporting reduced quality of care and reduced number of services to Medicare patients.

At the same time we see millions of dollars of profit being generated. The largest hospital chain in America, the Hospital Corp. of America, last year, 1984, reported a 22-percent increase in profits and a revenue increase of only 7 percent. Our trust funds are paying for new hospitals while bankrupting other hospitals with a commitment to serve.

Corporate takeovers now threaten to segregate hospital care. We urge you, our congressional leaders, to turn away from discussions of cuts and freezes and take time to examine where we are going and what the Nation's needs are with regard to safeguarding our health care now and in the future.

At the same time we, too, are concerned about deficits. And we urge you to restore the corporate tax in order to close deficits, not cut health care programs. As taxpayers we find it outrageous that for every $1 paid there are $1.42 in corporate loopholes generated by our tax system. Today corporate taxes account for only 8.5 percent of owed total Federal revenues as compared to 25 percent in 1960.

Study after study shows that loopholes do not produce investment, do not produce jobs. Just closing two loopholes, the ACR system and investment tax credit would generate $372 billion over the next 5 years.

We believe the current debate on how to cut Medicare is misdirected and morally wrong. Instead we urge you to consider restoring fairness to the tax system. The survival of the Nation's millions of hospital and nursing home workers depend on your leadership in defeating irrational and inhuman policies.

Thank you.

[The prepared statement follows:]

STATEMENT OF CATHY SCHOEN, RESEARCH DIRECTOR, SERVICE EMPLOYEES INTERNATIONAL UNION, AFL-CIO

Good morning Chairman Stark and Subcommittee members. I am Cathy Schoen, Research Director of the Service Employees International Union. On behalf of our President John Sweeney and our 850,000 members nationwide, I thank you for the opportunity to testify on President Reagan's proposed Medicare budget cuts.

MEDICARE CUTS IRRELEVANT TO FEDERAL DEFICIT

At the outset, we urge you to help abolish the myth that cuts in Medicare help to shrink the federal budget deficit. Five out of every seven Medicare dollars are obtained from a trust funds which is financed from a special payroll tax. Trust fund revenues cannot legally be used for any other purpose, including deficit reduction.

Thus, President Reagan's $19 billion budget cut proposals for 1986 through 1988 would largely create surplus funds in the trust funds. The President is merely using a budget accounting illusion that trust fund surpluses hold down the deficit. The federal government deficit remains unchanged regardless of the size of the Medicare trust fund surplus.

And, as you know, Medicare trust fund actuaries now report that Congress has already enacted changes in Medicare law that put the Medicare trust fund out of financial jeopardy for years to come.

It is time the American people were told that the cuts will not decrease the federal deficit—the cuts will merely make elderly and aged pay more and push to the brink of bankruptcy any hospital serving disproportionate shares of elderly and low income patients.

We urge you to take the lead in removing Medicare from the budget cut discussion. Decisions regarding Medicare policy belong only in the realm of what to do about long term trust fund stability.

BUDGET CUT PROPOSALS: BETRAYING A NATIONAL TRUST

Any civilized country takes care of its aging citizens, its disabled and sick, and its children. Access to basic health services is essential to the basic fabric of our society.

The Medicare program, combined with its sister program Medicaid, serves the sickest and most frail of our people—over 30 million senior citizens and/or disabled workers. Together these programs have contributed to dramatic improvements in the life span of Americans due to reduction in mortality and morbidity in most major disease categories.

According to the Congressional Budget Office, President Reagan's proposals would cut $44 billion out of Medicare and Medicaid over the next five years. The cuts would make every senior citizen pay more, impoverish elderly and disabled citizens living on subsistence incomes, and yet again increase the financial burden on private employers and union trust funds to fill in the increasing holes created in retiree health coverage.

President Reagan's proposals, in short, are ineffective and insensitive. Shifting costs away from the trust saves the federal government nothing while it betrays a national commitment and desire to take care of our sick.

Other witnesses today and yesterday have detailed the long list of bills President Reagan is presenting to retirees, the poor and hospitals and physicians providing services to these patients.

Virtually all proposed items make no sense. Increasing deductibles, higher premiums, a freeze on physician fees with no protections against patient overbilling, delaying eligibility one month, delaying coverage of workers over 65 yet again, and a freeze on hospital payments are all attempts to turn the federal government's back on its responsibility.

Meanwhile workers and employers continue to pay their social security taxes to finance the Medicare program. Citizens are honoring their part of the trust; the President should do the same.

We as a nation are at risk for turning the clock back on the quality and length of our lives. Today Medicare pays for less than half of the health care needs of retirees. Thanks to collective bargaining agreements and labor/management trust funds many retirees have been able to plug Medicare holes with supplemental insurance coverage.

Nationally retirees health care costs are skyrocketing because of previous cuts in Medicare eligibility, increase in deductibles and premiums, on top of rising health care costs. One of our union trust funds, for example, saw a $4 to 5 million increase in costs as a direct result of Medicare shifts.

Public and private employers alike are protesting such increases. Employers unfortunately are seeking to go back on past commitments to their retired workers.

Meanwhile millions of retirees with no supplemental coverage must choose between eating, paying rent, or health care—a choice none of us in this country should have to make.

As we have testified in the past, slashing payments to hospitals without regard to necessary costs of decent care, has already pushed those hospitals with a commitment to serve to the brink of bankruptcy.

SEIU represents 300,000 hospitals and nursing home workers across the U.S. and Canada. Because of the new DRG system and tight payment controls, our members in the U.S. already report widespread layoffs (particularly in inner city hospitals), and reduced care to Medicare and Medicaid patients.

Hospitals with a disproportionate share of Medicare and low income patients are now operating with skeleton staffs, deteriorating and sometimes dangerous equipment, aging facilities, and growing deficits.

The name of the game today is to admit only well-insured patients, easy-to-care-for patients, and to eliminate unprofitable lines of business, an ominous development for chronic care, emergency and outpatient services.

In this new environment, for profit corporate hospital chains are gobbling up facilities, and generating millions in profit due to their willingness and ability to manipulate Medicare and patient mixes.

The largest chain, Hospital Corporation of America, reported profit increases of 22% in 1984, $4.2 billion in revenue, only a 7% increase. The chain now owns or operates 400 hospitals, is buying up other multi-hospital chains, and is moving into health insurance, hospital equipment, home health and nursing home markets.

Such corporate take-overs of the profitable aspects of the U.S. health industry threaten greater segregation and inequity of care side by side with new Fortune 500 money making giants.

We urge you, our Congressional representatives, to turn away from discussions of cuts and freezes to take time to examine what the nation needs to do in 1985 to safeguard our health and the health of generations to come.

We need to expand, not contract, our commitment to decent health care and equity.

DEFICITS: RESTORE THE CORPORATE TAX

At the same time that we urge expansion of Medicare and Medicaid rather than cuts, we too are concerned about the massive federal deficits accumulated under President Reagan. We urge you to restore the corporate tax in order to close the deficit while preserving a federal commitment to decent health care.

As taxpayers, we find it outrageous that corporations do not pay their fair share of federal taxes. Recent studies reveal that corporations earn $1.42 in loopholes for every $1.00 paid in tax. Corporations with billions in profits over the last three years paid no taxes and received rebates of taxes previously paid.

Corporate income taxes have fallen by over one third as a proportion of national income since President Reagan took office. Today, corporate taxes account for only 8.5% of total federal revenues compared to 25% in 1960.

Yet study after study shows that these loopholes produce no economic benefits in terms of either growth, investment, or jobs. There is simply no reason to continue these blatant corporate welfare payments.

Closing just two loopholes—the 1981 accelerated cost recovery system and the investment tax credit—would raise $22.4 billion in 1986 and $371.7 billion over the next five years.

We believe that the current debate concerning how to cut essential people programs is fundamentally misdirected and morally wrong. Instead, we urge you to consider restoring fairness to the tax system as a solution to the deficit dilemma.

The health of senior citizens, the survival of hospitals and physicians committed to serving the ill, the working conditions of millions of hospital and nursing home workers, all depend on your leadership and rejection of President Reagan's irrational and inhumane proposals.

Thank you.

Mr. DONNELLY [presiding]. Mr. Gradison.

Mr. GRADISON. No questions, Mr. Chairman, thank you.

Mr. DONNELLY. Mr. Daub.

Mr. DAUB. You both may answer. In regard to your position on means testing under Medicare, should Medicare bring benefits to those who can pay to the same extent as those less able to pay?

Ms. SCHOEN. Yes. The whole purpose of the way Medicare was set up and the way we believe we should have a national health system set up is that everyone should be served equally without regard to income.

There are many nations who do this. And they show it is cheaper to provide care that way than the way we do now. With the Medicare system, by setting people on equal footing regardless of income, you involve everyone. You can create a one class system rather than multitiers where poor Medicare patients would be treated differently than wealthy Medicare patients.

Ms. TORDA. We agree that the quality of the Medicare system will best be maintained if everyone is equally eligible.

Mr. DAUB. Phyllis, you suggested that a continuation of the physicians freeze may discourage physicians from accepting assignments?

Ms. TORDA. Correct.

Mr. DAUB. Is there any evidence to confirm this?

Ms. TORDA. Well, the number of physicians accepting assignment has gone up dramatically in the last year. And that was with the understanding that this year's freeze would be for 1 year alone.

Mr. DAUB. Do you endorse the extension of the PPS system to physicians on a timely basis?

Ms. TORDA. Yes.

Mr. DAUB. Does AFSCME have a suggested plan for how this could be done?

Ms. TORDA. We could supply you that information.

Mr. DAUB. Thank you. That is all.

[The following was subsequently received:]

AMERICAN FEDERATION OF STATE, COUNTY
& MUNICIPAL EMPLOYEES,
Washington, DC, April 29, 1985.

Hon. HAL DAUB,
Longworth House Office Building,
Washington, DC.

DEAR CONGRESSMAN DAUB: At the recent Ways and Means Health Subcommittee hearing on Medicare Budget Issues, you inquired about AFSCME's proposed plan for extending prospective reimbursement to physicians. In response, I am enclosing the section relating to physician reimbursement from AFSCME's recently-developed model state hospital rate-setting legislation. I am also enclosing a two-part article from Washington Report on Medicine and Health discussing the different methodologies for prospectively reimbursing physicians.

Thank you for your interest in our position on this issue.

Yours truly,

PHYLLIS TORDA,
Health Policy Analyst, Department of Public Policy.

Enclosures.

A BILL To enact sections 100 to 122 of the Revised Code to establish the state hospital cost containment commission which is to regulate the gross patient service revenue of all hospitals throughout the state in an effort to contain raising hospital costs

Be it enacted by the General Assembly of the State of State:

SECTION 1. This act shall be known and may be cited as the State Hospital Cost Containment Act.

SEC. 2. It is the intent of the General Assembly to protect the public health and promote the public inerest by establishing a hospital cost containment commission to:

(A) limit the rate of increase in gross hospital revenues from year to year;

(B) protect and promote the quality and accessibility of hospital care available to the people of this state by assuring the financial viability of each hospital which is properly utilized and which delivers, efficiently and effectively, appropriate and necessary health care services of a high quality as required by its mix of patients;

(C) encourage hospitals to make the most efficient and appropriate use of the resources made available to them in providing quality care to patients;

(D) assure equitable treatment of all payers of hospital patient services, hospital employees, and hospital patients;

* * * * * * *

To the methodologies described in preceding sections of this Act. These circumstances shall include natural disasters; extreme financial hardship; closures of neighboring services or hospitals; increased cost for compensation of employees, including collectively bargained increases to correct for past lags in compensation compared to major collective bargaining agreements, collectivley bargained increases designed to correct for past discrimination, adjustments to remedy shortages of personnel or other adjustments necessary to maintain a qualified staff, and other circumstances to be itemized by the commission.

SEC. 109. (a) Within 12 months after the enactment of this Act the Chairperson of the Commission shall appoint a panel, not more than half of which is composed of representatives of providers of health care, to develop a methodology for reimbursing on a prospective basis physicians who provide inpatient services.

(b) Within two years after the enactment of this Act the Commission must submit to the legislature its proposed methodology for reimbursing physicians which provide inpatient services. The panel shall also study the feasibility of limiting the annual rate of increase for expenditures for services performed by physicians on an out of hospital basis.

SEC. 110. The Commission shall require the filing within specified deadlines of all reports, statements, and disclosures provided for in section 100 to 122 of the Revised Code or in rules adopted under those sections and Chapter XXX of the Revised Code. The Commission may also adopt, under Chapter XXX of the Revised Code, rules concerning penalties for failure to file reports, statements, and disclosures as required. Such penalties shall not be part of a hospital's allowed costs in determining regulated rates under sections 100 to 122 of the Revised Code.

[Washington Report on Medicine & Health, Perspectives, Feb. 18, 1985]

PAYING PHYSICIANS DIFFERENTLY

As physicians fight the Reagan Administration's fiscal 1986 budget proposal to extend the Medicare fee freeze for another year, the Health Care Financing Administration (HCFA) is examining options for controlling Medicare Part B costs on a permanent basis. HCFA originally was to submit to Congress by the end of this year a report on physician DRGs and a proposal to control Medicare physician costs, but Congress moved the report deadline up to this July. At a HCFA-funded conference sponsored last month by Project Hope, HCFA grantees for the first time reported on the results of their research into the subject. Their findings are expected to influence the report that HCFA utlimately will submit to Congress, and to figure in Congressional debate as well.

Investigators at the conference reported on various alternative Medicare physician payment mechanisms—everything from alternative fee-for-service systems (such as relative value scales) to per case payment mechanisms (such as physician DRGs), per episode mechanisms, capitated systems, and other payment modalities, such as "special procedure packages," that fell in between categories. For each mechanism, the major questions concerned who should be paid, who should be at risk, and what incentives would be created.

THE CURRENT SYSTEM

Speakers pointed out several problems with the current fee-for-service system, which is based on customary, prevailing, and reasonable (CPR) charges. The primary complaints were that the system is inherently inflationary and also includes incentives for providing unnecessary services and for unbundling services. Between 1980 and 1983 the cost of Part B services increased at a rate of 20.4 percent annually, according to HCFA. Since premium charges have not keep pace, the impact of Part B services on general revenues has increased about 28 percent annually. While some of the increased costs are related to increases in Medicare enrollment, which rises about 2.5 percent annually, much more is attributable to increases in the number of services provided per enrollee and to specific increases in the payment per unit of service, as well as to general inflation. Over-all, according to David Juba of the Urban Institute, 40 percent of Part B increases are due to general inflation, 12 percent to residual inflation, 34 percent to increased utilization, and 13 percent to enrollment increases. Within these basic categories, much of the inflation is related to greater reliance on specialists, Juba says. Many critics of the CPR system charge that it maintains pricing distortions, which reward new services over established ones, inpatient services over comparable outpatient services, and procedural services over cognitive ones.

While physicians oppose the Medicare fee freeze, some investigators oppose it as well, although for a different reason: they feel it is not effective. Despite the fee freeze, Medicare Part B costs are projected to rise 12 percent or more this fiscal year. Under the current system, which is based on CPT-4 billing terminology, charged Health Economics Research (HER) President Jerry Cromwell, physicians can indulge easily in "procinflation," or upgrading of services for billing purposes. For example, because of CPT-4 terminology, a bronchoscopy can be billed under any one of 15 codes and a routine physical examination can be characterized as "interim," "comprehensive," or "extensive"—each with its own CPT-4 billing code. It is difficult for physicians, let alone third party payers, to discriminate among these terms so that upgrading for billing purposes could be difficult if not impossible to detect. Physicians also can respond to the freeze by unbundling services (charging separately for services that were once considered a unit) or through making reciprocal referrals for consultations with their peers.

MD DRG'S

One of the possible alternative Medicare physician payment mechanisms of most interest to Congress is that of paying physicians, as well as hospitals, on the basis of DRGs. Proponents argue that through providing a flat payment per case based on diagnosis, incentives for unbundling or providing unnecessary services would be eliminated (although incentives for increasing admissions would remain, while incentives for underproviding services would be created.) Paying physicians for inpatient care on the basis of DRGs would align the incentives for physicians with those currently in place for hospitals. This alternative received a great deal of attention at the Project Hope conference.

An important question, addressed by HER vice-president Janet Mitchell, was how well physician DRGs potentially could reflect actual resource costs. This obviously would depend on the amount of variation in the physician resources expended in various DRG categories. Based on examination of millions of 1982 Medicare claims from four states (Michigan, New Jersey, North Carolina, and Washington), HER determined mean physician DRG payments on the basis of the average Medicare reasonable charges for all physician services provided during the hospital stay.

Mitchell found that costs for surgical DRGs were quite homogeneous within DRGs, with low coefficients of variation (0.40 or lower), implying little variation in physician services. Medical DRGs, in contrast, varied dramatically (with coefficients of variation from 0.70 to more than 1.50 within specific DRGs), "suggesting that physicians would end up being either significantly under or over paid in nearly every case" under the system.

While surgical DRGs followed a traditional distribution curve, medical DRGs showed a marked right skew, with most treatments falling at the low end of the cost scale, while a few treatments cost significantly more. Over-all in the four states, surgical DRGs explained from one-half to four-fifths of the variations in physician costs, while medical DRGs explained only 6 percent to 19 percent. (The 19 percent figure was obtained in Washington which has a greater homogeneity of treatment patterns than other states, largely due to a shorter length of stay that results in less opportunity to order other services, Mitchell says.)

The states varied greatly in medical practice patterns, especially in the extent to which they used discretionary services, such as assistants at surgery, consultations, and routine hospital visits by the family doctor. Physician DRGs, like hospital DRGs, would have the potential of reducing geographical variations in practice patterns, Mitchell says.

As with hospital DRGs, providers under physician DRGs would receive a flat payment regardless of services provided. Assignment would be mandatory. If physicians could treat the patient for less than the DRG payment, they could retain the savings. If treatment cost more, they would have to absorb the loss. (If assignment were not mandatory, physicians could accept assignment for low cost cases, retaining the savings, while refusing assignment for high cost cases and passing along the excess costs to the patient.)

DRGs would create significant potential for massive individual physician gains and losses. Since the average physician has relatively few Medicare inpatient cases, it would be unlikely that the distribution of expensive and low cost cases would average out. Mitchell estimates that the average physician would admit about two to two and one-half patients in each of about 15 DRG categories. Thus there would be very little averaging at the individual DRG level, and even averaging across DRGs would be limited.

Furthermore, gains and losses would vary by specialty. Over-all general practitioners would make gains (about $26 per case) over the current system, while the more specialized practitioners such as cardiologists could lose money (about $89 per case). This would not be a net loss, Mitchell stressed, but a loss from current payment levels. That is, if cardiologists did not change their behavior in regard to ordering tests, consultations, and other discretionary services, they could expect to forgo about $89 of their fees.

RISK POOLING DRG PAYMENT

Since the risk of catastrophic loss due to a few expensive cases could prove unacceptable for physicians under a DRG system, most researchers recommend some form of risk pooling. The particular form of risk pooling recommended is closely tied to another issue: who should receive the DRG payment?

Two possibilities mentioned for both risk pooling and DRG payment purposes are group medical practices and hospital medical staffs. Mitchell's research found that centering DRG payment on hospital staffs, unlike paying individual physicians, would not result in the creation of big winners and losers. For the vast majority of medical staffs, Mitchell says, aggregate DRG outlays would equal or exceed the staff's current Medicare charges. Relatively few staffs would lose more than $100 per case (from current payment levels), although teaching hospitals would be somewhat more likely to lose money.

According to Mark Pauly, director of the Leonard Davis Institute of Health Economics at the University of Pennsylvania, there are distinct trade-offs in deciding on the size of the group to receive payment. The larger the group, the greater is the possibility of risk pooling. Despite the presence of residual risk, however, the incentives for appropriate behavior diminish rapidly with increasing group size. If payment were located within a medical staff, Pauly says, utilization review would help control behavior as individual financial incentives were lost, but rules could prove hard to enforce. Another possibility would be the development of smaller groups within medical staffs or group practices. The smaller groups would feel the system's financial incentives more directly while enjoying some risk-sharing advantages.

Alternatively, Pauly says, a gatekeeper physician could receive the entire DRG payment and pay for patient services out of this amount. This doctor would have strong incentives for keeping costs down, but the risk spreading properties would be poor unless stop-loss insurance were purchased. (Lloyd's of London recently offered stop-loss insurance for hospital DRG outliers.) Incentives also would be created for the physician to avoid necessary consultations and to underprovide services.

How would physician DRGs affect beneficiaries? Assuming that assignment were mandatory and current cost-sharing requirements remained in place, Mitchell projects that 82 percent of patients would be relatively financially unaffected. About 9 percent would have their annual out-of-pocket expenses reduced by more than $75, while 9 percent would be liable for an additional $75 or more annually. Those facing the largest increases would be those with shorter, less expensive stays while those gaining under the plan would be those with longer, more costly stays.

SPECIAL PROCEDURE PACKAGES

Research thus far indicates that the variability of resources expended within medical DRGs would make them impractical, while surgical DRGs are more homogeneous and therefore more feasible as a payment mechanism. The potential problems with a large number of MD DRG categories has led HER President Cromwell to suggest a compromise to a full DRG system that would retain some of the advantages of "bundling" or "packaging" services rather than paying for them separately as is done under the current fee-for-service system.

This compromise would involve bundling physician services around well-defined procedures, such as coronary bypass surgery or bronchoscopy. A flat payment would be made for these "special procedure packages." Payment would cover the services of all physicians involved with the procedure, such as the surgeon, assistant surgeon, and anesthesiologist, as well as any associated tests and x-rays. This payment method also could be used when the procedures were performed in an out-patient clinic or office, encouraging use of ambulatory settings. In some cases, such as DRG 209 which covers both hip reconstruction and total hip replacement, the procedure package also could create more homogenous cost groupings than the DRG system. Under the special procedure package system, however, much care would remain unpackaged.

EDITOR'S NOTE.—This is the first of two articles on alternative physician payment mechanisms. The second article will appear in next week's Perspectives.

[Washington Report on Medicine & Health, Perspectives, Feb. 25, 1985]

PAYING PHYSICIANS DIFFERENTLY, PART TWO

(This article continues the discussion, begun last week, of alternative methods for paying physicians under Medicare. At a HCFA-funded conference sponsored last month by Project Hope, HCFA grantees reported on the results of their research into the subject. Last week's Perspectives reported on their studies into physician DRGs and special procedure packages. This week's article, reporting on other cost control methods, concludes the report.)

RELATIVE VALUE SCALES

While Congress has expressed interest in paying physicians as well as hospitals on the basis of diagnosis related groups (DRGs), physician advocacy groups, such as the American Medical Association (AMA) and the American Society of Internal Medicine (ASIM), have shown more interest in the use of relative value scales (RVS). An RVS ranks different physician services and procedures in order of their value or difficulty or resource use and gives each an RVS rating. Using the scale, an insurer such as Medicare can see that procedure X is ranked as being worth three times as much as procedure Y. The insurer can convert the scale to a fee schedule by assigning a dollar value to the RVS unit. If, for example, a procedure were given an RVS of 3, and the conversion factor were $30, the fee would be $90.

A fee schedule determined through RVS retains some of the features that conference participants criticized in the current fee-for-service system. Most important, it continues incentives to overprovide services and to unbundle or disaggregate services into a greater number of smaller, billable tasks. However, according to investigator Robert Berenson, MD, an RVS could be an improvement over the current system since it could be used to adjust existing fees, which are distorted and "out of line" in relation to one another. Through development of an RVS, it would be possible to eliminate the current bias in the system that rewards new services over established ones, inpatient services over outpatient services, and procedural services over cognitive ones.

Berenson discussed five alternative methods for establishing an RVS. A relative charge approach would be based on current physician fees. After distributing the range of fees for a particular procedure, a point in the distribution (mean, mode, median, etc.) would be chosen to represent the procedure's value. Then the values of all the procedures would be ranked to determine the RVS. This method, while relatively easy to accomplish, would perpetuate current distortions. Another method would use physician time or resources as the RVS basis. The time basis could be adjusted to allow for the value of other inputs such as training requirements and overhead costs. In certain specialties such as radiology, Berenson says, there would be particular difficulties in developing the scale since time itself is a relatively small part of the production cost.

Another method, microcosting, attempts to account more completely for the cost of each procedure. According to Berenson, microcosting, which builds in allowances for complexity, labor, and equipment, is best for equipment-intensive procedures. Unfortunately, microcosting studies, which involve time/motion analysis, would be very costly and would need to be updated often as technology changed.

Statistical cost functions, based on economic theory and analysis of multiple variables, attempt to estimate the value of each procedure under ideal conditions. Berenson reports, however, that is is difficult to incorporate a large number of cost functions into a single product and the statistical reliability is unknown. In addition, much more detailed data than are currently available would be needed.

The last method discussed involved consensus development, relying on expert opinion and/or group decisionmaking processes to determine relative values. The problem with this method is that there is no "correct solution." The RVS developed would reflect only group preferences where individual group members have different interests in the outcome—which would vary considerably from group to group.

In the past, relative value scales, such as one developed by the California Medical Association in the 1950s, have run to antitrust problems. However, Berenson and other experts believe it unlikely that an RVS developed by the government or another third party, rather than by providers themselves, would face the same challenge.

While officially opposing the compulsory use of an RVS that made no allowances for regional cost variations, the AMA has been involved in discussion with HCFA about the possibility of doing studies on the subject. The AMA House of Delegates adopted a resolution late last year that labeled RVS "less disruptive" than MD-DRGs and found them a potentially "acceptable alternative" to them.

CONTROLS ON SERVICE VOLUME

A system based on fee schedules derived from relative value scales would continue the fee-for-service system's incentives to overprovide services. However, according to Lynn Etheredge of the Urban Institute, restructuring fees also could contribute to volume (and cost) control. Economic incentives in the current system create problems in service mix, he charges, so that physicians provide too many of some services and not enough of others. Payment rates could be adjusted upward to provide more incentives to provide those services considered desirable and adjusted downward to provide fewer incentives for provision of services Medicare deems less desirable.

Developing more direct controls on volume of services could provide another alternative for controlling Medicare physician costs. One possible form of control, mentioned by Etheredge, who formerly served as the Office of Management and Budget's health staff chief, is the areawide budget. In this cost control method, currently in use in Quebec, health care budgets are established for particular geographic areas. If volume of services increases to the point at which costs would exceed the budget, the price per service is decreased.

Other volume controls include utilization review, currently in place of Medicare in this country, and administrative rules. For example, Medicare could require preadmission certification, second opinions, or case management through gatekeeper physicians. Etheredge also mentioned greater beneficiary cost-sharing as a volume control.

CAPITATION

While a system that provides a payment for each unit of service can encourage overprovision and unbundling of services, capitation provides the ultimate packaging. Under a capitated system, Medicare would pay a fixed amount per person to an entity that would assume responsibility for financing and/or providing all necessary health services during a fixed time period. Going beyond per case and per episode methods of payment, the capitated payment would remain constant regardless of the number of services provided or the number of illnesses or episodes treated over the entire time period. The incentives created are the opposite of those created by a per procedure form of payment—that is, capitation could provide incentives to "skim" the healthier beneficiaries and to undertreat. Underprovision and nonprovision of care resulted in California's pre-paid health care scandals of the early 1970s, but evidence thus far has not revealed a problem with underprovision of services generally in health maintenance organizations (HMOs), which traditionally operate on a capitated basis. HMOs recently gained the right to enroll Medicare beneficiaries on a capitated basis, providing both Part A and Part B services.

It is also possible, however, to address the problem of Medicare physician costs by capitating Part B services only. One of the primary issues involved in doing so is the question of what entity should receive the capitated payment. Stan Wallack, director of the Center for Health Policy Analysis and Research, discussed two possibilities at the Project Hope Conference. One approach would be to pay health plan or pysician group for providing directly all Part B physician services to an enrolled population. A capitated plan covering only physician services is currently part of Michigan's Medicaid program, but very few data are available so far.

The other approach involves paying a geographic entity (such as a carrier) for all eligible beneficiaries in the community and using the fee-for-service market. A carrier capitation system, in which the carrier was to some extent at risk for costs above the established budget, would provide a way for Medicare to increase risk-sharing in the fee-for-service system, Wallack says.

Under one possible form of this plan, a carrier could receive a capitated payment to cover all fee-for-service providers, Wallack says. The payment could be negotiated based on the area's historical costs. The carrier would then be at risk for costs within a relatively narrow risk corridor (for example, a 9 percent risk corridor with the carrier at risk for 15 percent of that). In order to avoid losing money and to become eligible for sharing in any savings, the carrier would develop cost saving mechanism such as utilization and payment controls, including the development of preferred provider plans. The carrier capitation plan could apply to both parts A and B of Medicare, or to Part B only Medicare would benefit by establishing limits on total spending and by sharing in savings, Wallack says. Currently two Medicaid programs, the Texas Purchased Health Services program and the Redwood Health Foundation (RHF) in California provide models for carrier-at-risk systems. Although these two programs have met expenditure goals for more than 10 years, critics of the carrier capitation idea believe that the system's incentives are diluted through being too far removed from the providers themselves. The RHF answers some of that criticism through the risk sharing arrangements it has developed with a number of area providers.

CONSUMER INCENTIVE PLANS

While some cost containment schemes provide incentives for providers or carriers to reduce costs, others, such as beneficiary cost sharing, act on the consumers of medical care. Increasing beneficiary cost-sharing provides negative reinforcement (i.e., greater costs) for "undesirable" behavior such as seeing expensive providers. However, a consumer incentive plan that allowed beneficiaries to share in the savings resulting from their costcutting actions would provide positive reinforcement for desired behaviors as well.

Joey Hay, a policy analyst with Project Hope, presented a Medicare consumer incentive pricing plan that he believes would provide these incentives. A prerequisite of the plan would be the elimination of the Medigap policies that currently insulate beneficiaries from the cost-sharing consequences of their health care buying decisions.

Under the plan, a beneficiary would designate a particular primary provider such as an HMO or other group plan, and Medicare would set target expenditures based on the average per capita Medicare expenditures in that area. All providers would be directly reimbursed by HCFA. After the plan began, the aggregate expenditures for the plans would be broken down to reveal their average per capita costs. If the provider kept costs below the target level, the group's patients would receive monthly premium rebates. If the costs were above the average, the patients would pay a monthly premium surcharge.

Hay reasons that under this plan, providers would attempt to keep costs below target levels in order to be competitive in attracting patients. Consumers, he believes, would have the freedom to choose the provider with the desired practice style. If a consumer preferred a more expensive practice style, he or she could choose a more expensive provider and pay the premium surcharge.

Critics of the idea question whether providers would compete on this cost basis and are uncertain that consumers would have the cost and quality information available to them that would allow them to make the types of decisions Hay envisions. They further question the amount of control a consumer has over the type and quantity of care a physician provides. In addition, individual risk-sharing incentives would be diluted in large groups.

Mr. DONNELLY. Mr. Gregg.

Mr. GREGG. Would either of you support—to follow up on Mr. Daub's questions—an adjustment to Medicare, which would be along the lines of the Social Security adjustment, which would raise the age of qualification prospectively?

Ms. SCHOEN. I guess, to reemphasize what I originally said, I believe current actuary reports are showing the Medicare Trust Fund with a surplus. Right now we are out of financial jeopardy. And some of the changes we have made in the past are supporting the trust fund.

I see no need for disenabling people from eligibility. In fact, what is happening to delay eligibility in terms of Medicare, you are seeing employers looking at a working age person as a liability to them, they are very costly. And I think by doing that we can in fact create an unemployment act for the elderly working. And there is no reason to throw them out of the labor force.

Mr. GREGG. Do I take it that your answer is no?

Ms. SCHOEN. Yes.

Mr. GREGG. Is that your position also?

Ms. TORDA. Yes, it is. It would just be a cost shift. And the Medicare system is more efficient than a lot of private insurance.

Mr. DONNELLY. Cathy, you stated in your written statement there has been a decline in the quality of care in hospitals with a disproportionate share of low-income patients. Has this been documented?

Ms. SCHOEN. We are starting to do surveys of our hospitals that we represent for what is happening. And the way we track it is elimination of some services that were provided before, some outpatient services, some special chronic care services in many hospitals, and also a drastic staffing reduction.

In addition to that, what we are trying to do is gather more complete information. We have been working with the ProPAC to do this as well. We are also seeing many reports in the nursing home end and also on the discharge end, people being discharged too early or inappropriately to nursing homes which are getting patients that they are not staffed to take care of. They are far sicker than usual.

At this point I do not think there is any comprehensive way of saying this is exactly what is happening, how much quality reduction. But it is a problem that I am encountering everywhere I go, patients not knowing what is happening to them. They just say why is this happening to us?

Mr. DONNELLY. Thank you.

Are there any additional questions?

If not, thank you very much.

Our next panel is Mr. Willis Goldbeck, president of the Washington Business Group on Health; Mary Nell Lehnhard, vice president of Blue Cross-Blue Shield Association; James Moorefield, president, Health Insurance Association of America. Welcome.

Mr. Goldbeck.

STATMENT OF WILLIS B. GOLDBECK, PRESIDENT, WASHINGTON BUSINESS GROUP ON HEALTH

Mr. GOLDBECK. Good morning, gentlemen.

My name is Willis Goldbeck, and I am president of the Washington Business Group on Health, a national association of major employers interested in health policy in America.

We come before you to urge you to not take any steps which would further delay or inappropriately freeze progress in the development with respect to payment system.

That may seem somewhat surprising in that people have suggested that we ought to have a knee jerk reaction: If you could freeze everything, that would, therefore, be beneficial to the business community.

On the contrary, we believe the prospective system is working, probably better than anybody expected it tc. Part of that rapid rate of progress is also a fairly rapid exposure of some problems with the system that need to be addressed and cannot be addressed by freezing it, only by working with it.

The update factors that Dr. Altman described—and they are in his report—clearly represent a far more analytical approach to what the Medicare system needs than an approach that says regardless of need let's not give it anything new. The single greatest threat to the development of a well designed, well implemented national prospective payment system is a decrease in access, a perception of the failed ability of Medicare to deliver the services for which it is committed.

A system like PPS sits on a fragile base of public trust and professional trust. And whereas it is not easy to deal in legislative terms with things like trust, I would suggest that the freeze is a very damaging attack on the trust of the profession and all of those who are in the process of trying to implement something for which many of them were certainly not in favor to begin with.

So we do not support the freeze. We do support the continuation of prospective payment and its improvements. We are concerned with the instability that the freeze would represent. We are concerned with a number of the budgetary proposals that seem to equate having someone else pay with the concept of savings. And, in a general sense, the deficit reduction by increasing poverty is not an acceptable approach even to the employer community.

The indirect graduate medical education factor is a hard one to comment on in terms of percentages because nobody will acknowledge what the right percentages are or how we got to the current percentages. The hearings held last week made that fairly clear when the administration could not say why they came up with any of the numbers they were proposing.

In the absence of a right number it is reasonable to expect that we will end up with a compromise number. And I would suggest, No. 1, that the Congress decide that this investment should go toward primary care, primary care residences, the greatest long-term investment.

And second, I would endorse the comment that Stu made, that those dollars should stay within the system, they should not be siphoned off to pay for a road, a bridge, or a bomb.

The freeze on medical education needs to be weighed against other competing social values such as access for all categories of our population to enter—not necessarily succeed in—but to enter the field of work that they wish. One must be concerned by the decreasing rates of minority opportunities in medical education in America.

The proposed 1-month delay is predicated on two false assumptions. One, that either nobody will get sick during that period of time and need care, or that they will not have a negative health impact which requires a larger expenditure later. And second, that employers will automatically just continue to pay for those 30 days because presumably all those Medicare people come out of an employment setting in which they have some form of retirement medical benefits. And that is statistically not correct.

Related to that is the concern arising from a number of these proposals. There seems to be the presumption that the corporate community will always continue its benefits no matter what changes the Government makes. And I urge you not to believe that.

Because, there will be a point at which retiree medical benefits, which are not required by law, spousal benefits, which are not required by law, become too onerous. And that will result in the private sector shifting back to public. This kind of juggling is not progressive for any sector, certainly not for the elderly.

So let me close by urging you to not let budget reduction or deficit reduction become a wedge to further strike a barrier, a gap, between the private and public sectors in providing care for the elderly. We need a cooperative, more cohesive venture, not a disparate venture.

[The prepared statement follows:]

STATEMENT OF WILLIS B. GOLDBECK, PRESIDENT, WASHINGTON BUSINESS GROUP ON HEALTH

As President of the Washington Business Group on Health, it is my pleasure to present this distinguished Committee with the concern and interests of many of our nation's largest purchasers of medical care. Our membership list is Appendix B.

Historically, business was not an active or well informed participant in the development of Medicare. Today, fortunately, leading employers know that they must be involved.

Before addressing the specifics of the Administration's budget proposals, a few contextual remarks are in order.

1. The need for a financially sound, well designed Medicare program has never been greater. All changes to Medicare should be considered not as methods to preserve what was, or systems for producing short term savings, but rather as efforts to make Medicare fit the real needs of our aging population for the years to come.

2. For those of us who advocate a more market forces oriented medical system, preservation of access to quality care for those without the economic means to enter the market is essential. The greatest threat to a successful transition to market forces are the current increases in poverty, the uninsured and inappropriate underservice of patients by dollar-driven providers.

3. Medicare can become a greater contributor to the market by purchasing care from high quality efficient providers. Simply reducing benefits and giving providers of all types the economic incentives to underserve will result in short term savings and long term political pressures for new governmental programs.

4. Medicare, declared prematurely bankrupt last year, is being prematurely hailed as solvent this year. It is time we were given an honest assessment. Solvency is being achieved by drastically shifting program costs to beneficiaries and employers. Solvency for the future is predicated upon freezing fees for providers who were promised an orderly phase-in of the Prospective Payment System, and by (according to the White House study group) borrowing billions from the same Social Security program which two years ago was borrowing from Medicare. Government is playing an accounting game in which the losers will always be the elderly and the taxpayer.

5. The health sector must contribute to our overall deficit reduction efforts. There is, however, no "fair share" on which Congress or the Administration can rely to avoid making tough choices. Freezes are the thoughtless approach. Deciding what we need and can pay for is the real challenge.

6. The drive to achieve deficit reductions from Medicare should be balanced by reforms that make Medicare inherently more efficient and programmatically more in tune with real needs. To do so involves risk taking, experimentation, new types of research and new outlays for services which hold the promise of long term cost effectiveness. A few examples:

(1) Reauthorize and expand the hospice program; (2) conduct research that will establish outcome standards to reduce the variation in physician practice patterns; (3) create new legislative methods for employers to pre-fund retiree medical benefits; (4) reimburse for prevention; and (5) reimburse for non-physician providers where the literature clearly shows cost and quality effectiveness.

I respect the Chief Counsel's admonition that this hearing is restricted to the Administration's proposal. The comments above do not violate that principle but rather serve to show explicit deficiencies in the proposal.

ADMINISTRATION PROPOSAL

A. Freezes

Unless all programs, including defense, are frozen, we oppose the Medicare freeze. A more complete statement on the freeze is attached as Appendix A. The central points are:

1. The Prospective Payment System should be allowed to complete its development phase-in on schedule.

2. The Congressionally established ProPAC should be listened to, not subverted by the freezes.

3. The freeze will result in decreased acceptance of assignment at the very time increases are needed.

4. The freeze rewards the very hospitals and physicians who have been least efficient during the past year.

B. Indirect medical education reduction

The amount of the addition should be decided based on our goals and needs for medical education. At the House Energy and Commerce Committee hearings on this subject, HCFA could not explain why 5.8 or 11.9 were ever selected, or what the result of the return to 5.8 would be. Thus, we are left with no analytical basis upon which to make a choice. Since this absence of information may make a change more politically acceptable—probably at some compromise level—then we urge you to seize the moment to direct this funding where it will do the most good: primary care residencies.

C. Direct medical education freeze

We support this proposal. However, we are mindful that one result could be to exacerbate an already significant problem, the reduced access to the medical profession for minority students and those of poor economic status. We are a nation of rapidly changing colour and ethnicity. The medical profession cannot be virtually closed to major portions of our population, or, conversely, open only to one economic class.

D. Delayed start of Medicare coverage

These are not real savings and cannot be promised. The success of the proposed change is dependent upon two factors beyond control of the government:

1. People who forgo care during that month, it is assumed, will not get that care in the future, nor will they suffer any determination which requires more expensive treatment as a result of the delay. There is no evidence to support these assumptions.

2. Beneficiaries in transition from employer plans will remain covered by those plans. Another unsubstantial assumption. Employers have no obligation to fill this new gap. Many will, however. Congress must recognize that each case of government shifting the cost of Medicare provides further incentives for employers to stop providing retiree benefits completely. Why should employers believe that this concept will be limited to one month: if it saves money, surely it could be extended to the first 3 months, or 6, or the first year.

This is an innocent sounding proposal that claims savings which cannot be guaranteed and portends greater costs to government through reduced employer commitments to retirees.

E. Secondary payer for working beneficiaries over 69

Contrary to what you might expect, we accept this proposal. It has been our position that employers should be the primary payer for all employees, regardless of age. There are, however, two cautions that arise when this proposal is viewed from a more broad, societal perspective.

1. The proposal is just one more direct economic incentive to employers to refuse to hire or retain older workers. The fact that our organization accepts the intellectual integrity of bearing primary responsibility for employees of all ages does not mean that employers of all sizes across the country will act accordingly.

2. By including the spouses of workers over 65 in employer-covered insurance, Congress should be aware that there is no mandate requiring employers to provide family coverage. Each new cost shift is just one more incentive to employers to shift right back by eliminating the benefits.

F. Copays for home health visits

This is an acceptable concept but we urge Congress to study the impact because savings achieved in home health that result in increased hospitalization and emergency room visits are not real savings. There is nothing wrong with co-payments as long as we do not lose sight of our objective, which is to increase home health because it is often economically and medically superior.

G. Part B premiums and deductibles

For some in the Administration, these increases are viewed as a shift in burden to beneficiaries. Suffice to say, the overwhelming majority of employers that provide retiree medical insurance are absorbing the premium and deductible costs of their retirees. By increasing those costs, the government would give one additional incentive for employers not to provide retiree medical coverage.

CONCLUSION

Our responses to the Administration's proposals derive from the context presented at the start of this statement and from the principal that future contributions by Medicare to deficit reduction should be the result of reform, not benefit reduction.

We are convinced that there are savings to be achieved through reform that equal or exceed those in the budget proposal.

We are convinced that Medicare can use its buying power to increase the economic freedom of beneficiaries, increase competition, support managed care systems, decrease fraud, decrease unnecessary and inappropriate care and increase quality by establishing outcomes validated standards of excellence.

Let me close by noting my concern for the repeated call for a reduction in the proportion of our economy devoted to health and especially the care of the elderly.

We are totally in favor of reform but even the most casual reading of demographic trends, gains in longevity, new medical technology and the value Americans place on health leaves one with the conclusion that we will continue to spend more on health . . . and that is just what the vox populi wants.

The challenge for Congress, and for business, is not to contain the percent of GNP devoted to health but rather to maximize the amount of health which results from the allocation of those resources.

[Appendix A]

WASHINGTON BUSINESS GROUP ON HEALTH

POSITION STATEMENT—PROPOSED MEDICARE FREEZE

The Washington Business Group on Health recognizes the importance of reducing the federal budget deficit. Controlling medical care expenditure escalation is essential to accomplish this endeavor. However, we do not support the proposal to freeze physician and hospital fees in FY'86.

As an organization of major employers, we are fully aware of the problems of excess hospital capacity, practice variation, unnecessary medical tests, and the economic incentives (historically encouraged by the design of employee benefit insurance) that have resulted in the unacceptable rates of medical care cost increases experienced in the late 1970s and the early 1980s. It was these conditions which caused the WBGH to support Congress and the Reagan Administration when the Medicare Prospective Payment System (PPS) was developed. We believed then, and reaffirm today, that this system reform was necessary and, although of a regulatory nature, was actually a vital step in providing the economic incentives which would lead to a more competitive medical care market place.

Our support for PPS continues for the best of reasons: the system is working. Virtually, every major medical care economic indicator has turned down after years of unfettered escalation. Medicare's PPS combined with the Peer Review Organizations (PROs), reasonable local planning, responsible employer and labor cost management strategies have resulted in dramatic reduction in cost increases.

While the medical care cost problem is not solved and many other difficult issues such as malpractice reform and disclosure of provider-specific quality measures remain, significant progress has been achieved.

As with other reform, the nation has paid a price for these collective accomplishments. Tens of thousands of hospital employees have lost their jobs as hospitals have closed, reduced in size, or merged. Medicare beneficiaries and millions of employers are paying a larger share of their medical insurance. Physician fees for Medicare are currently under a freeze. Economic competition is now a regular feature of medical decision-making.

For these sacrifices, more has been gained than just a reduction in cost escalation. The consumer has more and better information to make informed choices about the quality and price of care. Hospitals are responding to the economic incentives to be more efficient. Physicians have incentives to form groups, work in HMOs, provide preventive services, and reduce excess procedures. Employers, unions, insurers, and government are learning to purchase medical care prudently and to accept the fact that more care does not necessarily result in better health.

The Administration's proposed freeze would be a setback to the progress described above and would threaten the availability of quality care for many older Americans.

The freeze is not system reform, it is a unilateral disruption of the Prospective Payment System in its most sensitive stage of development. It would render useless a $3 million a year commission created to objectively determine annual increases in the Medicare budget.

Freezing PPS may result in a mere shifting of charges to other payers, such as the elderly and private sector payers. Physicians and hospitals must be given clear rules to follow and consistent government policy that can be trusted. The freeze represents a broken promise and thus threatens the viability of the entire PPS reform.

If the freeze were to be enacted, it would achieve these dubious results:

1. Provide new incentives for physicians to refuse Medicare assignment; in turn, this means either more costs passed onto elderly patients or services denied.
2. Provide new incentives for hospitals to reduce services rather than increase efficiency, leading to new access concerns. PPS rewards efficiency but a freeze rewards those who had the most inflated costs the previous year.

3. Provide increased pressures on public hospitals for which Medicare fees will also be frozen.

4. Encourage hospitals and physicians to shift charges to private sector purchasers such as WBGH members and unions.

5. Force Medicare recipients to buy more Medigap insurance—which is really just another form of shifting costs to the beneficiary—or to spend down and thus burden Medicaid programs with additional budgetary pressures.

While there is no denying the importance of deficit reduction, there is also no denying that Medicare should not continue to bear a disproportionately large share of the burden. Freezes of short duration and on only selected segments of selected industries have a long history of failure in the U.S. economy. One need only note that the largest increases in medical charges in history took place immediately after the Economic Stabilization Program controls were lifted in 1974. The proposed freeze will melt and leave the public awash in a rising sea of predictable price increases. No long term savings will be achieved and the chances for true PPS reform will have been derailed.

The proposed freeze also focuses on our national priorities. Medicare is a program costing $68 billion from which three-year savings of more than $22 billion are being sought. The defense budget exceeds $300 billion, yet three-year savings of only $28 billion have been agreed to. Its projected 11 percent increase for FY86 is out of step with freeze proposals and budgetary restraint rhetoric.

As employers with rapidly growing medical benefit costs for retirees and dependents and increasing numbers of older workers, our members are even more cognizant that the welfare of our over-65 population is a responsibility that must be cooperatively shared. We must invest in healthy aging for a period of longevity that was not even contemplated a few years ago. The freeze is contrary to all these goals.

Opposing the freeze proposal does not mean that the medical care cost problem has been solved. Significant budget savings from the medical care system can be achieved.

Following are just a few positive proposals that can be adopted:

1. Allow the PPS to go forward as planned, with no delays but also no unscheduled freezes.

2. Include a small, fixed amount for capital in the DRGs, replacing the current capital pass through. The percentage allowed should be less than the historical 6-7 percent due to the current and ongoing reduction in the use of our existing hospital facilities.

3. Provide incentives for the use of HMOs by Medicare recipients.

4. Establish a Medicare long term care program that combines home care, institutional care, and social services with varied financing plans including a health IRA, government support, and the availability of private insurance.

5. Reform the medical liability system so tort is the method of last, not first, resort.

6. Establish a prevention program that invests in healthy aging, rather than waiting to pay acute care costs for deterioration, much of which could be avoided or delayed.

7. Utilize the tax code to encourage employers to pre-fund retiree medical benefits through appropriate incentives rather than threatened penalties.

8. Require the public disclosure of price and quality comparative information that will enable the elderly and their advocates, including management and labor, to become truely informed consumers.

9. Establish a new equitable system of paying for medical education.

10. Encourage targeted DRG adjustments by the Prospective Payment Assessment Commission (ProPAC), including a reduction in hospital payments where new technologies and treatment have generated considerable profit margins for hospitals.

Medicare patients, the other payers of care for the elderly, and the providers have all been doing their share to reduce the role of medical expenditures, and thus lessen the deficit pressures. These efforts are working and will continue as a more efficient medical market is achieved within the regulatory guidelines necessary to assure access. However, neither Medicare nor even the entire medical industry can be expected to shoulder the major responsibility for reducing the deficit that itself was primarily the result of tax and defense spending policies, not excesses by payers, providers, or consumers of medical care.

[Appendix B]

WBGH MEMBERSHIP LIST AS OF DECEMBER 12, 1984

AMAX
AMF
ARA Services
ASARCO
AT&F
Aetna Life & Casualty
Air Products & Chemicals
Allied Corp.
Aluminum Co. of America
American Can
American Cyanamid
American Express
American Home Products
American Med. Intl Assn.
American Natural Resource
American Standard
Armco Inc.
Armstrong World Ind.
Atlantic Richfield
Bank of America
Beatrice Foods
Bechtel Power Corp.
Bethlehem Steel
Bell Comm. Research
Boeing
Boise Cascade
Bristol-Myers
Buck Consulting Act.
Burlington Industries
Burlington Northern
CPC International
CIGNA
Campbell Soup
Carter Hawley Hale
Caterpillar Tractor
Champion International
CHEVRON
Chrysler
Chase Manhattan
CIBA-GEIGY
Citibank
Coca-Cola
Colt Industries, Inc.
Continental Group
Control Data Corp.
Corning Glass Works
Crawford & Company
Dana Corporation
Deere & Company
Dexter Corporation
Digital Equipment
Dresser
EDS Federal
E.I. duPont de Nemours
Eastman Kodak
Eckerd, Jack Corporation
Eli Lilly
Equitable Life
Ernst & Whinney
Exxon
FMC
Federal Express
Federated Dept. Stores
Firestone Tire & Rubber
Ford Motor
GTAX Corporation
GTE Serv. Corporation
General Electric
General Foods
General Mills
General Motors
General Signal
General Tire & Rubber
Georgia-Pacific
Goodrich Company, B.F.
Goodyear Tire & Rubber
Grace, W.R.
Heinz, USA
Hewlett-Packard
Hoffman-LaRoche
Honeywell
Hospital Corp. of America
IBM Corporation
Inland Steel Company
International Harvester
Jewel Companies
John Hancock
Johnson & Johnson
Kaiser
Kimberly-Clark
Kroger Company
LTV
Lincoln National Life
3M Corporation
Macy, R.H.
Manufacturers Hanover Trust
Marriott Corporation
Massachusetts Mutual Life
Mercer, William M. & Co.
Merck
Merrill-Lynch
Metropolitan Life
Milliken & Company
Mobil Oil
Monsanto
Morgan Guaranty Trust
Motorola
Nat'l Chain Drug Stores
Nat'l Medical Enterprises
Northern Telecom
Norton Company
Olin
Owens-Corning Fiberglas
Owens-Illinois
PACCAR
PPG
PHH Group
Pacific Telesis
Penney, JC
Pfizer
Philip Morris
Pioneer Hi-Bred Intern'l
Pitney Bowes
Polaroid Corporation
Procter & Gamble
Provident Life
Prudential
Quaker Oats

RCA
Ralston Purina
Reynolds Metals
Rockwell International
Rohm & Haas
SCM
Sears, Roebuck & Co.
Shell Oil
Sherwin-Williams
Southern Calif. Edison
Southern New England Tele
Sperry Corporation
Staley, A.E., Mfg.
Std. Oil (Indiana)
Std. Oil Co. Ohio
Stanley Works
Stauffer Chemical
Stouffer Corporation, The
Sun Chemical
TRW
Tenneco
Texas Eastern
Texas Gas Transmission
Transamerica Occidental
Travelers
Union Camp
Union Carbide
Union Oil of California
Union Pacific
U.S. Steel
Valley National Bank
Wang Laboratories, Inc.
Warner Lambert
Wausau Ins Companies
Weyerhaeuser
Westinghouse
Whirlpool
Woodward Ryan Sharp & Davis
Wyatt Company
Xerox

Associate Members

Blue Cross/Grtr. Philadelphia
Health Ind. of America
Health Risk Management
Inst. for Health Maintenance
Medstate Systems, Inc.
Meidinger
Rodale Press
TCA, Inc.

Mr. Donnelly. Thank you.

Mary Nell Lehnhard.

STATEMENT OF MARY NELL LEHNHARD, VICE PRESIDENT, BLUE CROSS & BLUE SHIELD ASSOCIATION

Ms. Lehnhard. Thank you. We appreciate this opportunity to appear before the committee.

Our comments are based on our experience both as Medicare intermediaries and carriers, and as a source of private supplementary coverage for about 9½ million Medicare beneficiaries.

I will move right to the administration's proposals. First, if Congress determines that Medicare beneficiaries should bear a greater share of Medicare's costs, we believe that an increase in the premium is preferable to increases in deductibles and copayments.

Premium adjustments spread the cost to all beneficiaries rather than targeting only those beneficiaries who have immediate need of services.

The proposed increase in the part B deductible would hurt beneficiaries when they are ill and can least afford out-of-pocket costs.

We oppose the simple extension of the fee freeze because of the negative effect it would have on the physicians who have agreed to participate. We know from our experience that participating physicians programs offer the best promise for both controlling physician payments and protecting patients from unexpected and excessive liability.

A better approach would be programs like those sponsored by Blue Cross and Blue Shield plans under which physicians agree to accept the plan's allowable charge as payment in full. We believe that the new Medicare participating physician program, which appears to be responsible for increasing the assignment rate to 67 percent, promises substantial beneficiary protections.

Many physicians, however, have entered into this new agreement with the promise that they would receive a specific future financial consideration. We strongly urge you not to break that faith, but to offer every feasible incentive to participate, including a financial incentive, even if more limited than initially promised.

The administration's budget also proposes to freeze payments to hospitals for medical education programs.

With respect to hospital prospective payments, we believe that the proposal to freeze the fiscal year 1986 rates by regulation should be reviewed carefully to determine if it takes into account what was required by law which was an amount necessary for the efficient and effective delivery of medically appropriate and necessary care of high quality.

If the regulatory freeze fails this test, the Congress may nevertheless feel compelled, because of budget pressures, to affect a freeze by changing the law. If you do so, we believe it should be accompanied by an improvement in the accuracy of the DRG rates through the introduction of a severity of illness measure or other refinements.

If these improvements are not feasible by October 1, their prompt development and implementation should be given the highest priority. In addition, if a freeze is enacted, we would urge a delay in the transition to national DRG rates.

A longer transition period would better enable hospitals to adjust to the effects of a freeze and should moderate extreme changes in any individual hospital's payments.

We believe that the current method of paying for direct medical education costs should be retained until a method is available to isolate and pay for only those costs related to patient care. The adjustment cost for indirect medical education appears to be inaccurate, but we are not sure that halving this adjustment would improve its accuracy.

We strongly believe the best approach would be to introduce severity of illness adjustments to more fully reflect the resources needed by teaching hospitals.

The administration's budget also recommends enactment of a voluntary voucher to buy private coverage equivalent at least to Medicare benefits. We believe the best promise of overall Medicare savings is through providing managed care and by introducing market-based efficiency incentives while assuring adequate beneficiary safeguards. The voucher may be one approach in this direction.

Although the voucher plan may hold promise, it is not in legislative form. Therefore, it is difficult to comment on its viability. We can provide more specific comments on this proposal once it is in legislative form.

Finally, while we recognize that this hearing is focused on Medicare program changes, we believe it is extremely important that the subcommittee recognize the problems facing the administrative structure of Medicare, the underpinning of the program.

This year the administrative structure of Medicare will face a serious problem. The proposed funding level for this critical function will demand cost reductions, which far outstrip the ability of the contractor community to meet through increased operating efficiencies. The shortfall in contractor funding will have serious implications for controlling program payments, implementation of program changes, and the day-to-day services that intermediaries and carriers provide to the Government, its beneficiaries, and providers of service.

We will be sharing our concerns about the adequacy of the proposed funding level for contractors with the Appropriations Committee which has jurisdiction over this part of the program. However, we would like to work closely with this subcommittee in evaluating the effects of new program changes on Medicare administration. In addition, once again we would appreciate gaining the subcommittee's support in reenforcing the policy that severe restrictions in the resources devoted to Medicare program administration are penny wise and pound foolish.

[The prepared statement follows:]

STATEMENT OF MARY NELL LEHNHARD, VICE PRESIDENT, BLUS CROSS & BLUE SHIELD ASSOCIATION

Mr. Chairman and members of the Subcommittee, I am Mary Nell Lehnhard, Vice President of the Blue Cross and Blue Shield Association, the national coordinating agency for all Blue Cross and Blue Shield Plans.

Thank you for this opportunity to comment on the Medicare proposal contained in Administration's Fiscal 1986 budget. Our comments are based on our experience both as Medicare intermediaries and carriers, and as a source of private supplementary coverage for 9½ million Medicare beneficiaries. We recognize the importance of reducing the federal deficit and providing appropriate incentives for the efficient and effective delivery of health care to Medicare beneficiaries. Our comments today will address the major Medicare program changes proposed in the Administration's budget as well as our concerns about the administrative structure of this important program.

As you consider what are essentially short term methods of achieving savings, we suggest that you be guided by four program needs:

(1) Maintenance of an adequate level of beneficiary protection; (2) stability in administration; (3) appropriate incentives for quality and cost-effectiveness; and (4) continued experimentation to provide the knowledge necessary to make ongoing refinements to the program.

In particular, we ask that you consider the following points as you review the Administration's Medicare proposals:

If Congress determines that beneficiaries should bear a greater share of Medicare costs, increases in premiums are preferable to increases in deductibles or copayments.

Further expansion of the provision making Medicare the secondary payer for "working aged" beneficiaries and spouses should be accompanied by adequate lead time and increased efforts to assure a clear understanding of any changes among all affected parties.

In considering the proposal to extend the physician fee freeze under Part B of Medicare, all efforts should be made to maintain or enhance the incentives for physicians to become "participating physicians."

Any action to freeze temporarily hospital prospective payment rates should not divert attention from the need for refinements to the payment system such as severity of illness measures. The proposal to freeze FY 1986 rates by regulation should be reviewed to determine if it takes into account amounts necessary for the efficient and effective delivery of medically appropriate and necessary care of high quality, as required by current law. If a statutory freeze is enacted, we would urge that the Congress delay for the duration of a freeze the transition to national DRG rates.

The current method of paying for direct medical education costs should be retained until a method is available to isolate and pay for only the cost of patient care. The adjustment for indirect medical education costs appears to be inaccurate, but halving this adjustment would not necessarily improve its accuracy. We believe that the best alternative is to introduce severity of illness adjustments to more fully reflect the resources needed by individual hospitals.

The proposed voucher concept should receive attention and Congress should begin exploring the feasibility and advisability of areawide carrier capitation as another cost-effective approach to the financing and delivery of Medicare services.

A stable administrative structure is critical to the control of benefit payments, the timely and accurate handling of claims, prompt response to beneficiary and provider inquiries, and the smooth implementation of complex program changes.

We would now like to address these points in greater detail.

PROPOSALS AFFECTING BENEFICIARIES

Among the Adminstration's proposals affecting beneficiaries are proposals to increase the Part B premium, expand the "working aged" provision, index the Part B deductible, and introduce a copayment for home health services.

If Congress decides that some sort of increase in beneficiary cost sharing is necessary to help reduce the deficit, we believe that the most equitable approach would be through Part B premium adjustments. Premium adjustments spread the cost burden among all beneficiaries, rather than targeting only beneficiaries who have need of services. The proposed increase in the Part B deductible also would hit beneficiaries when they are ill and can least afford out-of-pocket costs. Beneficiaries now share significantly in the costs of Part B services—through the premium, the deductible, and the coinsurance—and some beneficiaries cannot afford even this level of cost-sharing. At some point, Congress should consider whether lower-income beneficiaries need additional protection.

The Administration also proposes to expend the so-called "working aged" requirement to beneficiaries and their spouses aged 70 and over. This would be an extension of the working aged provisions approved in TEFRA and DEFRA. If Congress decides to require private insurance to take on greater responsibility for financing health care for the elderly by adopting this proposal, we urge that adequate lead time be provided to minimize disruption and confusion. For example, two government agencies have jurisdiction on this issue, and they previously promulgated conflicting regulations that were not issued until well after the original law's effective date. We are concerned that the employers of beneficiaries could have another unexpected administrative burden as a result of the current proposal, and that beneficiary and employer confusion could result if the implementation period is too short.

PROPOSALS AFFECTING PROVIDERS

We oppose a simple extension of the physician fee freeze because of the negative effect it would have on those physicians who have agreed to participate—that is, to accept assignment on Medicare claims in all cases.

We know from experience that participating physician programs offer the best promise for simultaneously controlling physician payments and protecting patients from unexpected and excessive financial liabilities. The vast majority of Blue Cross and Blue Shield Plans have physician participation programs under which participating physicians agree to accept Plan payments as full reimbursement for services delivered to their subscribers. We believe that the new Medicare participating physician program, which appears to be responsible for increasing the assignment rate to 67% of all physician and supplier claims, promises substantial beneficiary protection. All of those responsible for this program are to be commended for this achievement. We encourage you to make all efforts to retain and increase the viability of the participating physician program.

Many physicians, however, entered into Medicare participating agreements with the promise that they would receive specific future financial consideration because of their participation. We strongly urge you not to break that faith but to offer every feasible incentive to participate, including a financial incentive, even if more limited than was promised.

We believe that the participating physician program and the claim-by-claim assignment option for other physicians should be continued for an additional period before any decision is made about eliminating it, or replacing it with an untried reform. We believe, however, that the Medicare program should eventually eliminate the selective claim-by-claim option for physicians, and provide maximum incentives for physician participation. We believe that this policy, over time, offers the greatest potential to increase the Medicare assignment rate because it takes full advantage of the changes that are occurring in the market for physicians' services. As the supply of physicians and beneficiary understanding of this simpler system increased, the marketing advantages of becoming a Medicare participating physician would likely increase. Finally, this policy would better position Medicare to experiment with and ultimately adopt some of the innovative cost containment approaches now being used by the private sector, such as preferred provider organizations and selective contracting. We recognize that no solution will be perfect, but believe that a strong participation policy will, on balance, be most advantageous to the program and its beneficiaries.

The Administration's budget also proposes to freeze payments to hospitals and other institutions and to reduce hospitals' medical education payments. With respect to hospital prospective payments, we believe that the proposal to freeze FY 186 rates by regulation should be reviewed carefully to determine if it takes into account amounts "necessary for the efficient and effective delivery of medically appropriate and necessary care of high quality," as required by current law. If a regulatory freeze fails this test, the Congress may nevertheless feel compelled, because of budget pressures, to effect a freeze by changing the law. If Congress enacts a freeze, it should be accompanied by an improvement in the accuracy of the DRG rates through the introduction of a severity of illness measure or other refinements. If these improvements are not technically feasible by October 1, 1985, their prompt development and implementation should be given the highest priority. In addition, if a freeze is enacted, we would urge a delay in the transition to national DRG rates. A longer transition period would better enable hospitals to adjust to the effects of a freeze and should eliminate extreme changes in any individual hospital's payments.

In regard to payment for medical education costs in teaching hospitals, the Administration proposes to freeze direct medical education costs—which are now paid on a reasonable cost basis—and to cut in half the adjustment for indirect medical education costs.

Conceptually, direct medical education costs can be divided into two categories—those that are related to the actual provision of needed care to patients and are the responsibility of payers of health care, and those that are not. We believe direct medical education costs that are not related to patient care should ultimately be borne by some financing mechanism other than that intended to support patient care. Other sources of support include hospital philanthropy, hospital earned income, and federal and state support programs. This principle has always been recognized by Medicare as well as by Blue Cross and Blue Shield Plans. The practical difficulty is that there are no available data or methods to separate the costs into these two components. Moreover, recognition must be given to the availability of such alternative sources of support.

Blue Cross and Blue Shield Plans deal with these issues through negotiations with individual hospitals. Individual negotiations may not be feasible for Medicare. Recognizing this, the lack of adequate data, and the uncertainty of alternative financing, we urge caution in considering substantial restrictions in Medicare payments for direct medical education costs. We believe that the current method of paying for direct medical education costs should be retained, at least until a more precise method is available to isolate and pay for the costs of necessary patient care services provided by those involved in graduate medical education programs. Failure to recognize these costs would unfairly disadvantage teaching hospitals because those same services rendered in a non-teaching setting would otherwise to reimbursed under Part B of Medicare.

The indirect teaching costs adjustment is based on the fact that the cost of hospital care, on the average, tends to be higher in teaching hospitals than in non-teaching hospitals. Presumably, these costs are related not only to the practice patterns of interns and residents, but also to the characteristics of the patient population. Thus, a major argument for the teaching adjustment has been the higher costs associated with the sicker patients that teaching hospitals treat. The accuracy of the adjustment factor, based upon the relationship between operating costs per discharge and residents per bed, has always been debated. We share the Administration's skepticism regarding the accuracy of the adjustment. Doubling the adjustment may, in fact, have only magnified its inaccuracy. However, we would be equally concerned with arbitrarily reducing the total simply by cutting it in half.

We believe the best approach to recognizing necessary higher patient care costs of teaching hospitals is to introduce severity of illness indicators. This reinforces the importance of placing the highest priority on refinements that would improve the accuracy of prospective payment rates.

As you review all of the proposals that affect providers, we also urge you to consider the need for further efforts to monitor the quality of care under the new DRG system. Increased use of skilled nursing and home health services is to be expected under DRG incentives, but the appropriateness of increases in such care deserves attention.

VOUCHERS

The President's budget also recommends enactment of a voluntary voucher to buy private coverage at least equivalent to Medicare benefits. This would presumably represent a liberalizing of the recently implemented HMO/CMP option enacted by TEFRA. We believe the best promise of overall Medicare savings is through providing managed care and introducing market-based efficiency incentives, while enforcing adequate beneficiary safeguards. The voucher may be one approach in this direction. We are also encouraged by the approach of capitating carriers for the financing of Medicare services in a defined geographic area, which is now being discussed within the Administration.

The voucher plan may hold promise, but because it is not yet in legislative form, it is difficult to comment on its viability. Comments on the broad outlies of a voucher plan are also difficult because there is a delicate balance between protecting beneficiaries and making use of market driven provider efficiencies. We are also concerned about the potential for certain private plans to be selected by only less healthy and more expensive beneficiaries, and with the possibility that the voucher's purchasing power would be maintained at an adequate level only for the healthiest beneficiaries. A similar problem may occur under the current HMO/CMP option.

We would like to work with this subcommittee to provide comments on this proposal once it is in legislative form. In the interim, we suggest that you provide Medicare HMOs and CMPs with greater flexibility by permitting them to determine how any payment in excess of their adjusted community rate will be used. Market demands will generally call for any excess to be used for additional benefits; however in certain cases it may be appropriate to use some of their funds as capital to support an expansion of the organization's capabilities.

PROGRAM ADMINISTRATION

Finally, while we recognize that this hearing is focused on Medicare program changes, we believe it is important that the subcommittee to cognizant of the problems that face the administrative structure of Medicare—the underpinning of the program. These problems have serious implications for the control of program payments, the implementation of program changes, and the day-to-day services that intermediaries and carriers provide to the government, its beneficiaries, and providers of services.

For nearly 20 years, Blue Cross and Blue Shield Plans and their Association have performed Medicare administrative services under Part A intermediary and Part B carrier contracts. This has been one of the most successful public/private partnerships ever constructed. As the subcommittee well knows, we—the government and the contractors—have worked together through a lot of difficult times and we have always succeeded in getting the job done.

Since 1980, Congress has called on Medicare contractors each year to implement, in a timely and effective manner, numerous program changes. The recent hospital prospective payment system and the participating physician program are but two examples of the major challenges we have met effectively. These changes require contractors make major systems modifications, educate beneficiaries and providers, and make numerous other conforming changes.

Contractors have accomplished all these tasks with an administrative budget that is only 1.3 percent of program costs and declining. In spite of all the new demands, the average cost to process a claim has fallen from $2.49 in Fiscal 1981 to $2.23 today for Part A and by a similar percentage for Part B. Our program safeguard activities have demonstrated substantial savings for every dollar spent on them.

This year, the administrative structure of medicare will face a serious problem. The funding for this critical function proposed in the Administration's FY 1986 budget will demand cost reductions which far outstrip the ability of the contractor community to meet through increased operating efficiency. As a result, there is a high risk of a deterioration in service to beneficiaries and providers and a diminishment in the capacity of the administrative structure to control benefit payouts.

This subcommittee played a critical role in 1982 in assuring that adequate resources were devoted to administrative "program safeguard" activities such as audit and medical review. For FY 1986, while the proposed budget for "payment safeguards" appears adequate, it comes at the expense of funding for claims processing activities. It is critical to note, however, that effective claims processing is not only the foundation for good medical and utilization review, but is the first line of defense in preventing inappropriate benefit payments for non-covered services, duplicate claims and program abuses.

We will be sharing our concerns about the adequacy of the Administration's FY 1986 proposed funding level for Medicare contractors budgeting problems with the Appropriations Committee, which has jurisdiction over this aspect of the Medicare program. However, we would like to work closely with this subcommittee in evaluating the effects of any new program changes on Medicare administration. In addition, we would appreciate this subcommittee's support once again in reinforcing the policy that severe restrictions in the resources devoted to Medicare program administration are "penny-wise and pound-foolish."

SUMMARY

In closing, I would like to commend the Subcommittee for examining the effect of the budget's proposed Medicare changes, and reiterate our concern about the deficit and the rapidly rising costs of the Medicare program. We have emphasized the importance of a stable administrative structure to the Medicare program and have suggested specific issues to be addressed in your review of the Administration's FY 1986 budget proposals. We will be happy to work with you as you begin addressing these very difficult issues for which there are no easy solutions.

Chairman STARK. Thank you.

And Mr. Moorefield. Your prepared testimony will be made a part of the testimony. You can proceed to expand on that or summarize in any manner you like.

STATEMENT OF JAMES L. MOOREFIELD, PRESIDENT, HEALTH INSURANCE ASSOCIATION OF AMERICA

Mr. MOOREFIELD. Thank you. I appreciate the opportunity to be invited to participate in this hearing today.

I would like to start off with a note—being conscientious of the time—that we have filed a written statement. My remarks will therefore just highlight some of the points we wish to make.

I would also like to start off by speaking on a positive note because we feel that there now appears to be marked progress in our mutual struggle to contain health care costs, which has been the major objective of my association for a number of years.

Just to illustrate briefly, we find that the struggle with soaring health costs seems to be paying off. Economic reports indicate that inflation for medical prices has actually slowed down. Hospital utilization in the last year for some reason has also come down. Changing the incentives, as Mr. Goldbeck mentioned, from the cost-based system to a prospective pricing system for Medicare is working. And it is working better than we anticipated. We are also pleased to note that, if the current trends continue, the Medicare trust fund will not be in any problem until 1998.

I would also like to note—Mr. Gradison, sir, I think you asked this question of Dr. Altman earlier—that in addition to the States of Massachussetts and New York, that Maryland and New Jersey also have the Medicare waiver. Those programs are working well. Furthermore, in the last 2 years we have had the States of Maine, Connecticut, West Virginia, and the State of Washington pass similar legislation for cost containment purposes.

Mr. Gradison, in your own State of Ohio, I believe there is a movement to at least study the effects of an all payor prospective payment system. So we in the insurance industry are proud of what is going on.

We, too, are involved in the HMO and PPO movement, and we are experimenting with new ways of managing health care. We are promoting wellness. Just this year we implemented a nationwide wellness in the work site campaign. We have noted that through the efforts of all of us, particularly with the encouragement of our own industry, employers are abandoning first dollar coverages and are raising their deductibles and coinsurance amounts.

So a whole new dynamic has emerged, and that is good. But, we still have to be cautious. The high cost of health care is still a major problem for all Americans, including payers, the Government, individuals, and so forth. Which brings me to the Medicare freeze proposals.

We are particularly concerned about the proposal to freeze payments for hospitals, physicians, and other providers. Now, I understand that the fiscal year 1986, savings in Medicare as a result of these freezes is proposed to be about $3.2 billion.

As a practical matter, I think those providers who have been trying to adjust to the new DRG system will, as a logical business practice, try to recoup those Medicare reductions and the Medicaid cap by inflating their charges to the private sector; that is, private patients who already on average pay 12 percent more than Medicare and Medicaid patients for similar services.

That is cost shifting. And I do not believe I have to explain to this group how cost shifting places unfair burdens on certain hospitals and how it falls unevenly on private payors.

Regarding the graduate medical education proposals of the administration, reducing these payments, we believe, will further jeopardize the ability of the Nation's teaching hospitals to compete in these changing times.

Some have suggested that the hospital and physician freezes will be absorbed by the providers and will not be cost shifted and that the beneficiary will be protected. We do not agree. That is not our experience.

I have a lengthy part in my printed statement about the financial situation facing the Medicare contractors. To boil it down, we think there are insufficient funds being proposed for contractors in the fiscal year 1986 budget, particularly for everyday administration of that program, including claims processing.

And finally, although it is not apart of the budget proposal at this point, I think we are all aware that the administration will soon send a proposal to the Hill that would tax employee health benefits. For reasons that are in our statement and which you will be hearing more of, we think that is wrong. We think it is misguided. We think it is bad health policy, bad social policy, and bad tax policy.

Thank you for the invitation to meet with you. We will be happy to be of help in anyway we can.

[The prepared statement follows:]

STATEMENT OF JAMES L. MOOREFIELD, PRESIDENT, HEALTH INSURANCE ASSOCIATION OF AMERICA

Good morning, Mr. Stark and members of the subcommittee. I am James Moorefield, President of the Health Insurance Association of America. The HIAA is a trade association of approximately 325 companies which together write over 85% of the country's commercial health insurance. I appear today on their behalf, because federal health care financing and Medicare policy in particular greatly affects private health insurance companies and the way they do business.

When I last appeared before this subcommittee it was to support the enactment of Medicare hospital payment reform because we believe in the benefits of prospectively determined prices for hospital services. That approach works well in the states that have enacted all payer prospective payment systems, and now it's working for Medicare. I believe the Medicare experience is teaching us a great deal about the advantages of this change in incentives. Hospitals, with a new focus on efficiency, are changing their behavior and we are all benefiting to some degree from the result.

However, we argued then as we do now that the benefits of prospective pricing should be extended across the private sector as well. With Medicare on one track and most of the private system on another, hospitals and physicians are still free to shift costs not met by the Medicare program onto the private insurers and private employers.

The Medicare only prospective pricing system has indeed held down Medicare outlays. According to the Medicare Trustees Reports, disbursements from the Hospital Trust Fund in 1984 went up only 9% from FY 1983. That's good progress. Indications are there that 1985 may also be a good year in comparison with what's happened to health care costs over the past decade. But, I urge members of the subcommittee not to make overly broad generalizations based on one year's worth of data.

MEDICARE FREEZE

This brings me to our reaction to the Medicare provisions in the President's proposed budget. I particularly want to highlight our concern regarding a one-year freeze on hospital DRG payments, the physician fee freeze, and other provider payment freezes.

The FY 1986 savings to the Medicare program as a result of the arbitrary freeze approach is expected to be $3.2 billion dollars. That's $3.2 billion less to the nation's hospitals, doctors, home health agencies, and skilled nursing facilities than they had expected.

After long and careful study of the Medicare Prospective Payment System, the Prospective Payment Assessment Commission has recommended increases in DRG payments to hospitals in FY 1986 of from one to three percent. Even that is less than the amount hospitals would receive if they were allowed the expected rise in the hospital market basket.

What concerns us is what happens when the nation's hospitals, believing that they have diligently implemented the prospective payment system—producing significant programs savings as a result—are nonetheless hit with an arbitary $2 billion dollar cut in Medicare payments. I think hospitals will, as a logical business practice, try to recoup this Medicare reduction (along with Medicaid underpayments) by inflating charges to private patients. Those who are insured will face even higher premiums. Our actuaries estimate that for every $1 billion in additional cost-shift, the typical bill of a private patient will go up 1%.

Some have suggested that the hospital and physician freeze proposals, which make up 80% of the proposed savings in Medicare, will be absorbed by the providers and that beneficiaries will be protected. This is not our experience. It's the other consumers of health care services, the privately insured patients, who will ultimately pay for Medicare's so-called savings. Along with increased cost-shifting, we see signs that some providers may be discharging Medicare patients too early or reducing access for Medicare, Medicaid and indigent patients or reducing quality of care for those they admit.

Additional cost shift of this magnitude has the following consequences. First, it presents an unfair burden on hospitals that have a disproportionately large share of Medicare/Medicaid patients and a correspondingly reduced share of well-insured private paying patients. Since HCFA has yet to implement an adjustment for disproportionate-share hospitals, we see this as a growing national problem made worse by a freeze on Medicare payments.

Second, the Medicare cost shift falls unevenly on private payers. Increasingly, those private payers that reimburse on the basis of negotiated discounted rates as HMOs, a few PPOs, and those Blue Cross and Blue Shield plans with huge market shares avoid paying for much of the government shortfalls, uncompensated care and medical education. Payers without huge local market leverage and self-paying patients cannot escape a disproportionate share of this load.

It seems ironic to me that the Office of Management and Budget would recommend a policy of freezing Medicare which exacerbates the cost shift problem dramatically, and, at the same time, impede the ability of states to act on the problems of uncompensated care and costshifting by refusing to publish long overdue waiver regulations. Your Congressional directive to the Secretary of Health and Human Services to develop "waiver" regulations so that states can cope with the cost shift problem is being ignored by OMB. Such regulations are more than two years overdue.

GRADUATE MEDICAL EDUCATION

The administration's proposal to reduce graduate medical education costs also is expected to produce significant savings to Medicare. The failure of Medicare to share appropriately in the cost of medical education can only further jeopardize the ability of the nation's teaching hospitals to face changing times on a sound financial footing. It also further exacerbates the cost shift onto the insured private patients who receive care at teaching institutions.

It is inappropriate to arbitrarily reduce Medicare payments for medical education without debating more thoroughly the level of funding needed and an equitable source of funding. Until then, such cuts will not rationalize medical education costs but will put teaching hospitals and the insurers who pay them at a competitive disadvantage regardless of how efficient those parties are. Increasingly, competition will reward private payers who steer patients away from teaching hospitals and their higher costs.

WORKING AGED

Another savings proposal would make private employer health plans primary for active workers over age 70. This extension of existing law would affect only a very few individuals. While the cost of providing health benefits for individuals over age 70 is significantly greater than for persons just turning 65, the small number of active workers in this age group should not make the additional costs to employer health plans significant enough to create a dis-incentive to employ persons in this age bracket.

You should be aware that the HIAA, the Blue Cross and Blue Shield Association and other payor representatives are currently working with HCFA to make the administration of the existing Medicare working aged statutes operate more effectively.

MEDICARE VOUCHERS

We have been led to expect that the Administration will soon be sending you a Medicare voucher proposal. Not having seen its final form, it may not be appropriate for me to comment on the concept at this time. However, I do want to say this much. Developing a Medicare voucher proposal which will actually deliver on all the purported goals of saving Medicare money, expanding beneficiary options, and continuing quality care will be extremely difficult. I urge you to consider any such proposal with utmost caution.

MEDICARE CONTRACTORS

I now want to comment on that part of the Medicare budget which deals with the day-to-day management of claims payment, program safeguards, and beneficiary services. Ten commercial insurance companies participate in Medicare administration today. Each of these companies were there when the program began and have helped it develop into one of the best administered programs in government. Their record of reducing claims processing costs and increasing efficiency has been remarkable. Despite significantly increasing workloads, complicated changes in the Medicare program, and more than a decade of high inflation, the costs of administering Medicare claims has steadily declined year after year.

In past years, our general management experience and first hand knowledge of this program was respected and utilized by the Office of Management and Budget and by the Office of Program Operations at the Health Care Financing Administration. Today this is no longer the case. Our repeated warnings to HCFA that forced reductions in our claims processing budgets is damaging our ability to perform the important functions asked of us are being ignored.

In testimony before the House Appropriations committee a few weeks ago, Dr. Davis defended a FY 1986 budget request of $920 million for Medicare contractors. When specifically asked if this amount was "realistic" he replied that HCFA's original request was for $957 million.

Mr. Stark and members of the committee, I wish to tell you that there are presently insufficient funds in the program administration budget, especially for claims processing, to do all that needs to be done to insure smooth claims processing and to do all that we can to insure proper billing to the program. The proposed FY 1986 budget for claims processing represents an $18 million reduction from FY 1985 levels despite an increase of 10% in the number of claims processed plus inflation. For example, to meet current budget limits, contractors are being forced to reduce staff working on implementing the Medicare secondary program, valuable improvements in our computer systems are not possible, and more and more contractors are forced to make questionable reductions in employee costs such as going to unseasoned part-time claims processors who will work the overnight shift, accept sub par wages and give up fringe benefits.

Underfunding the claims processing function has meant reduced staff and overburdened computers which, in turn, has resulted recently in serious claims backlog problems for some of our most experienced and efficient of contractors. In our opinion, claims backlogs that result from underfunding contractors should not be tolerated. Huge additional incremental costs to the program result when providers and beneficiaries become impatient with time delays. They call, write, and demand valuable time and attention, further reducing the efficient use of staff and machines.

Money spent on increasing the contractors' ability to monitor fraud, abuse, and billing errors consistently brings in whopping returns. The return ratio for funds invested in program safeguards and medical review/utilization review exceeds 5 to 1.

In the recent Office of the Inspector General's Report to Congress, the Inspector General states that improved management commitments to recover funds and affect savings in 1984 produced $3.7 billion, a 164 percent increase over 1983. In the same report to Congress, the Inspector General says "Many of the highlighted activities related to health financing which are described in the report, can be directly attributed to the active support and cooperation of the contractor community."

With returns and results like this from investments in contractor activities, I simply don't understand why we have to be here calling your attention to the inadequate support we are getting from the Health Care Financing Administration and the Office of Management and Budget.

TAX ON EMPLOYEE HEALTH BENEFITS

While not officially a part of its Budget proposals to Congress, the Admininstration has put legislators on notice that it will soon be sending you a Treasury Department proposal which will recommend among other things, taxing employee health insurance benefits. That proposal, I believe, is misguided.

The burden of the tax cap would fall unequally on workers depending upon where they work, their ages and their occupations. The cap will discriminate against workers in areas where health care costs are relatively high—such as California and New York—where employers must pay twice as much or more for health care coverage as is paid in areas of relatively low health care costs—such as North Dakota. A recent HIAA study compared the impact of the proposed cap in various cities on the same comprehensive health plan. The increase in taxable income for workers covered by the plan (2-9 life group family coverage) was $4,320 in Los Angeles, $2,488 in New York City, $1,304 in Jackson, Mississippi and $616 in Greenville, South Carolina.

The tax would also discriminate against worker groups composed primarily of older workers whose health care costs are greater than those for younger workers. The average age of workers from industry to industry throughout the United States varies considerably. Plans covering workers with a higher average age are more costly and these workers would be subjected to higher taxes under the proposal.

Finally, the tax would fall disproportionately upon workers employed by small businesses and workers employed in high risk or hazardous occupations. Small businesses typically pay more for health care coverage because of higher administrative costs and greater variability of claim costs. High risk workers' costs are, obviously, higher because of the greater risks involved under their plans.

Imposing a tax on group health benefits could result in adverse selection as the young and healthy opt out of the plan, leaving older and less healthy members in the group to pay the cost of the plan. The resulting degeneration of plans would move the burden of providing health care to the government.

Current tax laws have long been recognized as playing a key role in the development of the privately financed benefits system. If the group insurance mechanism is to operate effectively, essentially all employees in a group must be covered. This is currently achieved by having the employer pay most or all of the premium, with employees paying no tax on the employer's contribution. If the cost to employees is increased by having some or all of the employer's contribution added to their taxable income, employees will begin to drop out. The first to leave the plan will be the young and healthy (who are at relatively low risk) and other workers who need the money. As a result, premium costs will rise for the older and less healthy employees who retain coverage. The spiral of higher premium, higher taxes and progressively fewer covered employees will have begun. The degeneration of plans will utltimately follow. It will be the lowest-income worker who will be hit first and hardest.

The tax cap would place essential preventive care in jeopardy as employers who want to avoid additional reporting requirements and employees who do not want additional taxable income will move towards limiting contributions to the amount which is not taxed. To avoid exceeding the proposed cap, employer contributions would concentrate on purchases for hospital coverage, and preventive protection is likely to be reduced. Dental and vision care, mental health benefits and alcohol and drug abuse services may be dropped from health care benefit plans in order to keep the employer's contribution below the cap. These are sound and needed programs and the resulting reductions in coverage will adversely affect them.

The tax cap adds more complexity, not simplicity to the tax law. The complexity arises from the processes and difficulties involved in computing the per employee costs around the country, reporting costs to employees, including the cost in the employee's tax return and auditing all of the above. If the tax cap is adopted, employers will have additional costs because of the requirement that they report the taxable amount for each participant in the plan. Isolating health care costs around the country which are subject to the computation will require a major effort. Building systems that will do this work will be complicated and costly, especially for small businesses.

The tax cap would not reduce overconsumption of health care. Although the Treasury asserts that the tax cap would be a significant tool to "reduce overconsumption", this is not the way to address it. Assuredly, there has been inflation in health care costs. The cost of health care is a problem for employers and employees regardless of whether a tax cap is imposed. It is a problem not just for private insurance programs, but the Medicare, Medicaid and people who have no insurance at all. Many employers are already making changes to alleviate the cost of the health care plans they now provide. This is going on without any changes in the tax system.

Traditional insurance plans are being modified to increase deductibles and coinsurance requirements so that individual employees have a greater interest in controlling their use of health care facilities. In addition, preadmission testing and second opinions before surgery are offered or required to reduce hospital stays and eliminate unnecessary surgery. Health care systems are changing with the growth of Health Maintenance Organizations, which emphasize preventive health care and Preferred Provider Organizations.

The net result has been to reduce significantly excessive health care cost inflation. For the twelve months ending September 1984, health care cost inflation was 1.5 times the CPI, down from 1.7 times in the twelve months ending December 1983 and 2.8 times in the twelve months ending December 1982. The problem of inflation in health care costs should be addressed and is being addressed through changes in the way the health care system works, not through an additional tax on workers.

CONCLUSION

Thank you, Mr. Chairman, for seeking our views. In my mind, private insurers and Medicare have a similar goal . . . how to get the best health care for the most reasonable price. I hope you find our years of experience in managing that goal useful in your deliberations.

Chairman STARK. Thank you. I would like to start with your last subject first. If an employee through tax reform ends up paying less total income taxes, what difference does it make whether or not we tax their health benefits?

Mr. MOOREFIELD. If that employee should end up paying less tax, I think he would probably favor that. However, it is the numbers with which we have some quarrel. How many would end up in that more favorable tax position?

Chairman STARK. According to the President, it would be 86 percent, I think, would pay equal or less—70 some odd percent, 78 percent.

Mr. **Moorefield**. We believe for working Americans, about 60 percent will be affected by additional income taxes due to the proposed tax on health insurance. Then we have to get into what the tax rate will be to determine the actual number.

Chairman **Stark**. But as long as people do not pay a lot more taxes, you do not care?

Mr. **Moorefield**. We think it will also cause the group health benefits system to unravel. As long as there will be some that are going to pay the higher tax, we fear that the young, the healthy, will drop out of the group benefits system——

Chairman **Stark**. I think you did not hear my question. I said as long as they do not pay any more tax, what difference does it make?

Mr. **Moorefield**. We believe it would cause the employer based group health insurance system to unravel.

Chairman **Stark**. Even if they pay no more income tax?

Mr. **Moorefield**. Yes, sir.

Chairman **Stark**. That is an interesting theory. Thank you.

I had another question for Mr. Goldbeck. I apologize for missing your testimony, but I was going through it here just briefly. It has been evidenced that there is a concern if we have Medicare cuts you will be forced into a development of a two-tier health system. And I wonder what you think is wrong with a two-tier health system?

Mr. **Goldbeck**. The rhetoric around a two-tiered health system is always a bit difficult to cut through. I think you could make a case that as a practical matter, we often already have a two-tier health system. It is probably a little Pollyannaish to suggest that everyone in the United States, even in the presence of Medicare 5 to 10 years ago, got truly equal care or equal access to care.

We run into problems today when you see increasingly clear divisions of access among entire population groups rather than on a more case by case basis. We are experiencing a rapid increase in the under-65 poverty population, unexpected progress in longevity with the result that all resources available to people over 65 are spread out over a much longer period of time, logical provider response to the economic incentives placed in front of them through PPS and through the private sector changes for which all of our organizations have to share in the responsibility: Together, these factors make clear that certain services that are essential—I do not just mean fringe stuff—essential services, quantities of services, categories of providers are not as available to a Medicare recipient as they were before. The second tier is increasingly at risk.

A previous witness spoke of the problems of people being moved out of hospitals into nursing homes prior to their being medically ready for such a transfer. In response to Mr. Daub's question, I do not know of a formal study that quantifies this yet, but I visit roughly seven cities a month all year long. I have not found one yet where this is not a regularly discussed and reported instance right now.

So we find more and more reasons to be concerned as to what that means, a second class of medicine. Part of the problem results from a tradition of asking the medical system and especially hospitals to compensate for society's shortcomings in housing, transportation, employment, or nutrition, to name just a few forces that are technically exogenous in the health system but consume many of its resources.

Another part of the problem is the instability and the uncertainty for the elderly American. What benefits are available from what source? Which provider to turn to? What will be the reimbursement prices?

We see this reflected in the inability of employees to take care of their own families, their own parents, in their role as general citizens. So I think it is something we all need to be concerned about.

If the Nation, if the Congress, wishes to say this is as much as we can afford, then at least it must have the foresight and the willingness to stand up and say this is what that second class will get. This is what we will provide and this is how we will do it. Don't just let it happen so that in some communities you have got 60 and 70 percent of the people in a medically indigent status, in others none or 2 percent. In our national rhetoric, we homogenize the Nation and our programs to a point that is often utterly irrelevant in anybody's hometown.

Chairman **Stark**. Thank you, Mr. Gradison.

Mr. **Gradison**. How do you feel about ProPAC's recommendation for the DRG update factor for the next fiscal year?

Mr. **Goldbeck**. I think it is a responsible analysis. You are starting in a situation where nobody knows a finite level to offer. The program began with somewhat undesirable factors that were of necessity: Using individual hospital's experience to establish their base rate. This would not be the way that you would like to start a program like this. But that was what we had to do. I think the analysis shows that ProPAC is proposing a very responsible next step, certainly more responsible and analytical than a blanket freeze.

Mr. **Gradison**. In many ways we are struggling in the legislative realm to apply the experiences of the private sector. How do you feel that mandatory second opinions for nonemergency surgery are working out in the private sector? And how would you feel about the idea of applying that to Medicare?

Mr. **Goldbeck**. I would be in favor of applying it. The only evidence in Medicare has been favorable when second opinions are mandatory. And in the private sector, to the best of my knowledge, there has not been a single voluntary second opinion program that has ever made major progress.

The mandatory ones work, for very logical reasons. And the ones that have now been in existence—and there aren't that many that have more than 6 years—show a continued surgery avoidance rate over that period of time of roughly 18 to 20 plus percent coming off the peak of the first year of 28 to 30 percent.

There is some drop off as people find themselves in need of some surgery. But that is a very high retention rate over a long period of time. It works when it is mandatory, it does not work when it is not mandatory, that is clear.

Mr. **Gradison**. I would welcome comments on that.

Ms. **Lehnhard**. We agree with that. With respect to moving a mandatory second opinion program into the Medicare Program, we would urge you to look at it carefully and consider a demonstration.

There are a number of problems we think inherent with the Medicare population. For example, our most successful programs are run out of an employer's shop. You have somebody there available on the telephone to answer an employee's questions. It is a very close relationship, a benefit management relationship.

We are not sure how effectively and efficiently you can transfer that to 25 million elderly Americans. But we would urge some demonstrations on using the mandatory program.

Mr. GOLDBECK. There is a real clear message that comes out of a lot of this panel, and other people's testimony as well. You want a system in which Medicare patients become the participants in some version of what we today call managed care. A process, not just access to reimbursement.

That is what works in other levels of the society, in other age groups it is proving to be successful. Managed care is a transferable system for groups of senior citizens as well as it is for others.

Chairman STARK. Mr. Donnelly.

Mr. DONNELLY. I have no questions.

Chairman STARK. Mr. Daub.

Mr. DAUB. Thank you, Mr. Chairman.

Do Mr. Moorefield and Mr. Goldbeck disagree on the thought that if the employer's health insurance is the primary coverage for older Americans who continue to work, then it will discourage the continued employment of older workers.

Mr. GOLDBECK. I do not know what he thinks.

Mr. DAUB. What do you think?

Mr. GOLDBECK. I think it is a distinct risk. The more you make it economically difficult and administratively onerous for employers to either hire or retain older people—and it would be true of any other category for which those same impediments arose—you place a formal governmentally induced disincentive or barrier to that employee.

So, yes, I think it is something to be concerned about.

Mr. MOOREFIELD. We have primary liability for the working aged now, up to 69. And even though the Government has not yet saved as much money as it expected—and we are all working together to correct that situation—we do not believe that extending employer liability for workers over age 69 as proposed would be a detering factor in hiring the elderly.

There are not that many workers working beyond 69 now. So we do not think it is a major consideration. It has some merit for budget reduction and we would not oppose it.

Mr. DAUB. I want to make one other comment about the testimony we have just heard. We really ought to take a good look, although it is appropriation's function, to the amount of funding for the contractor work.

I am interested in the subject. It is not necessarily in our domain, but we appreciate the testimony we are receiving on that.

Chairman STARK. Mr. Gregg.

Mr. GREGG. I would be interested in Blue Cross-Blue Shield's opinion as to how we can take advantage of the surplus bed situation in order to reduce costs to hospitals?

Ms. **Lehnhard**. Well, we think that reducing surplus beds is part of the needed fundamental reform in the health care system. We have a number of excess beds in the marketplace right now. If we could close those beds, divert the care to an outpatient basis, move more care out of the expensive hospital setting, we will be able to keep what looks like a very good trend in place.

Mr. **Gregg**. Have you folks done any studies yet as to what hospitals, generically or specifically, would be most likely to be effected in attempting to accomplish that efficiency?

Ms. **Lehnhard**. How they go about closing the beds?

Mr. **Gregg**. Right. Where?

Ms. **Lehnhard**. I would be glad to get back to you. We have an example in California. Other places it is a transition. In some cases the beds are converted to nursing home care. I think it depends on financial considerations and how much time the institution has to make bed reduction decisions.

Mr. **Gregg**. Have you done any studies or do you have any information regarding what other uses these beds can be put to that will be more cost effective, and whether or not they work in other uses?

Ms. **Lehnhard**. They can be put to use as nursing home beds providing they don't have high overhead costs. Sometimes you are almost better from a cost/benefit approach to start all over. Certainly where it is cost effective, surplus beds should be changed into long-term beds.

Mr. **Gregg**. You do not have any statistics?

Ms. **Lehnhard**. No. But I can check on that and get back to you.

Mr. **Gregg**. How about where we are approaching a surplus of doctors, or where we have a surplus of doctors, have you done any thinking on how you can best deal with that?

Ms. **Lehnhard**. We think it provides a great opportunity for both the private market and for Medicare. As we mentioned in our testimony, a participating physician program is much easier to support where you have a surplus of physicians.

We think that participation programs will better position Medicare over the long term to use this physicians surplus to move into innovative PPO arrangements, and selective contracting, without harming the beneficiary. I think Medicare should take advantage of it.

Mr. **Gregg**. Have you done any studies as to whether or not the cost reduction is about 25 percent in an HMO? Is the reduction driven by the fact that they serve healthier patients or because they are actually delivering care at a more efficient level?

Ms. **Lehnhard**. There is no doubt that patients in HMO are frequently healthier. They are generally employed. But we do have some studies that look at the utilization of a population before it goes into HMO, then look at their same utilization statistics once in the HMO. Those show a reduction in utilization.

There are not many studies like that around, but we have a couple.

Mr. **Gregg**. Do you have any experience with PPO's?

Ms. **Lehnhard**. PPO's, we can see the change overnight. You negotiate a discount with a hospital, you negotiate special utilization review arrangements. We have a case of a 25-percent reduction in an employer's premium cost; 12 percent is not uncommon.

Mr. **Gregg**. I am interested in that.

Chairman **Stark**. Thank you.

Mr. Goldbeck, I have just one more question. And I have a hunch if I read appendix A it will be answered. But on page 4 you refer to freezes, and then you have got four points. And I assume you mean what I refer to as the transition, and you also mean freezing the payments to hospitals. You are talking about a variety of freezes there.

And if I go to appendix A will it become abundantly clear to me where the freeze hospitals and physicians who have been the least efficient?

Mr. **Goldbeck**. I hope it is written intelligently enough so it will be very clear.

Chairman **Stark**. Thank you. I want to thank the panel for providing us with this excellent testimony. And we appreciate your cooperation.

Mr. **Jacobs** [presiding]. The witnesses will proceed.

Mr. Glaser, please proceed.

STATEMENT OF DAVID H. GLASER, EXECUTIVE VICE PRESIDENT, JEWISH INSTITUTE FOR GERIATRIC CARE, ON BEHALF OF THE AMERICAN ASSOCIATION OF HOMES FOR THE AGING, ACCOMPANIED BY HOWARD BEDLIN, LEGISLATIVE ANALYST

Mr. **Glaser**. Thank you. Good morning. We appreciate the opportunity for being able to address the subcommittee today.

I am David Glaser, the executive vice president of the Jewish Institute for Geriatric Care in New Hyde Park, NY.

It may be of some interest to you to know that this not-for-profit nursing facility averages about 28,000 Medicare days a year.

With me today is Mr. Howard Bedlin, who is the legislative analyst for the American Association of Homes for the Aging. And I am presenting testimony today on behalf of the association.

It should be noted that nursing home costs have not been a contributing factor in Medicare cost containment problems. SNF costs have consistently been below that of inflation. Very little savings will result from freezing that portion of the budget.

Nursing home expenditures constitute less than 1 percent of total Medicare spending, down from 6.2 percent in 1967. The projected savings of $5 million is not worth the tremendous difficulties beneficiaries would face in not receiving appropriate posthospital services they so urgently require.

It is important to understand that nursing home and hospital perspectives on Medicare are very different. Hospitals cannot survive without Medicare. Nursing homes can. And with little or no financial loss.

Remember, Medicare accounts for about two percent of nursing home revenue. While hospitals' census are at all time lows, most nursing homes have extensive waiting lists.

Our primary concern for opposing a skilled nursing facility Medicare freeze is obviously the tremendous access problem the elderly would experience in not being able to receive required posthospital services.

The statistics show that although the over 65 population is increasing, Medicare cover days have been declining dramatically. Between 1969 and 1977 cover days were reduced by over one-half. I am sure you are also aware of the severe shortage of skilled nursing facility beds in certain parts of the country. This increasing under supply of beds and services will only be exacerbated with a freeze.

Another access concern is the DRG's and their impact on skilled nursing facilities. The new hospital DRG prospective payment system is seriously increasing the demand for skilled nursing facility services. Three separate studies have documented the greater pressure nursing homes are now under to admit discharged patients under the DRG system. These patients are being discharged in a sicker state of health than before DRG's.

The current section 223 cost limits are keeping many providers from admitting Medicare patients. Can you imagine what an impact a freeze would have on future admissions? If a freeze is implemented, many providers would either drop out of the Medicare Program or severely reduce services. Congress thought only a few nursing facilities would be impacted under section 223. Are you aware that 35 percent of SNF Medicare providers are currently impacted by these limits? A freeze would probably increase that impact to over one-half of the providers.

If Congress is looking to reduce the Federal deficit by limiting Medicare expenditures, then look at total Medicare spending, not just the skilled nursing facilities spending. Expanding, not reducing nursing home Medicare benefits is the answer to cost reduction. Why? Well, first if hospitals are unable to discharge patients appropriately, these patients would become outliers in the system, resulting in higher Medicare payments. Second, hospitals may discharge to alternate settings exempt from DRG's, such as rehabilitation hospitals or rehabilitation units, where costs remain very high for Medicare services.

Third, further savings can be realized when the DRG system is recalculated with new data showing reduced hospital length of stay if SNF's are provided with adequate reimbursement. If we were to receive such reimbursement, then we would be inclined to admit that early discharged patient from the hospital. This, in turn, should result in shorter hospitalization for patients, with additional budget savings. Alternatively, if SNF's receive no relief, and access to posthospital care is restricted, new DRG calculated rates would be increasingly higher, and few, if any, Medicare dollars would be saved.

Gentlemen, the members of the American Association of Homes for the Aging, all not-for-profit agencies, exist for only one purpose, and that is to serve the frail elderly. Please do not tie our hands. It is difficult for us now to meet the needs for this population. Introducing a freeze at this time will drive many providers either out of the program or will drastically reduce the number of beds, services, and most important, quality care. Don't deny the elderly the services they require.

[The prepared statement follows:]

STATEMENT OF DAVID H. GLASER, ON BEHALF OF THE AMERICAN ASSOCIATION OF HOMES FOR THE AGING

The American Association of Homes for the Aging (AAHA) appreciates this opportunity to express its views on Medicare budget proposals as applied to skilled nursing facilities (SNFs). As the national representative of approximately 2500 nonprofit skilled nursing facilities, intermediate care facilities, housing, other health related facilities, and community related services for the elderly, we are extremely concerned about the SNF Medicare benefit and strongly oppose a freeze on this program's budget. AAHA members are sponsored by religious, fraternal, labor, private and governmental organizations committed to providing quality services for their residents and elderly persons in the community at large.

It should first be noted that nursing home costs have never contributed to the Medicare cost containment problem and very little savings would result from freezing the SNF portion of the budget. Unlike hospitals, increases in Medicare expenditures and per diem costs for SNFs have been consistently below the rate of inflation in the industry. Additionally, expenditures on nursing homes now constitute less than one percent of total Medicare spending—down from 6.2 percent in 1967—significantly lower than payments to physicians or home health agencies under the program, and even lower than the error rate in payments to hospitals. Projected savings of $5 million from a freeze of the SNF Medicare budget not only fails to consider the increases in total Medicare spending that would result, but is certainly not worth the tremendous difficulties that beneficiaries would face in not receiving the appropriate post-hospital services they now so urgently need.

It is important to understand that nursing home and hospital perspectives on the Medicare program are very different. While hospitals could not survive without the Medicare program, nursing homes could easily withdraw from the program with little or no financial loss. Medicare payments account for only less than two percent of the average nursing home's revenues. While hospitals' census is at an all time low, nursing homes have an average waiting list of 32 persons and could easily find other sources of revenue if Medicare payments fail to cover their costs.

BENEFICIARIES WILL BE DENIED ACCESS TO NEEDED SERVICES

The primary reason for AAHA's opposition to a SNF Medicare freeze is that it would create tremendous access problems for elderly persons needing post-hospital rehabilitation services. A spending freeze would greatly exacerbate the access problems that data reveal already exist for beneficiaries. SNF Medicare covered days per 1,000 elderly beneficiaries declined by over 21 percent between 1976 and 1982, dropping from 413.84 to 324.19 covered days. Since the number of persons over age 65 has risen significantly in that time, with an expected concomitant increase in demand, the reduction in covered SNF Medicare days suggests that availability of these services has declined at an alarming rate. Another shocking statistic reveals that total covered days were reduced by over one-half between 1969 and 1977, dropping from 14.4 to 7.1 million days. Without barriers to access, Medicare beneficiaries' covered days surely would have increased.

The shortage of SNF Medicare beds is even more severe in certain parts of the United States. In 1982, 42 states had fewer than ten nursing homes with an average census of at least 16 Medicare patients; 30 states had less than five such Medicare-oriented facilities; while twelve states had no such facilities. In 1980, one-half of the non-metropolitan counties and 17 percent of the metropolitan counties lacked any certified skilled nursing facilities.

In that year, over half the elderly population in five states (Iowa, Louisiana, Nebraska, New Mexico, and Oklahoma) lived in counties without SNFs; in another eight states more than one quarter of the elderly were in similar circumstances. The proportion of the elderly living in rural areas without SNFs exceeded 50 percent in eleven states and over 80 percent in four states.

These figures reveal only a small part of this dangerously increasing undersupply of needed services. Of major new concern is the skyrocketing demand for SNF Medicare services that has arisen as a result of the new hospital DRG prospective payment system. By providing incentives for hospitals to discharge patients much earlier than before, the DRG system has caused a tremendous increase in beneficiaries' need for post-hospital rehabilitative SNF Medicare services. If reducing length of stay is the criterion, DRGs are working, as length of stay in hospitals has declined from 9.5 days to 7.4 days in the past year. If hospital reimbursement rates are frozen, hospitals' financial incentive to discharge patients quickly will be even greater, and SNFs will be unable to provide the heavier care needed by this sicker patient population. Three studies have documented the greater pressure nursing homes are now under to admit discharged hospital patients.

The National Center for Health Services Research found, "About 70 percent of discharges to nursing homes stayed beyond the average for their DRGs compared to only 48 percent patients with a regular discharge period. Elderly Medicare patients needing long term care services would account for about nine days of unreimbursed care per discharge compared to three days for a patient discharged to self care." The report documents that many patients discharged to nursing homes required a longer than average stay in the hospital and, therefore, would have been financial "losers" for the hospital. Clearly, such patients are much more likely to be discharged prematurely.

A second recently released study, conducted by the U.S. General Accounting Office at the request of the Senate Special Committee on Aging, reports "patients are being discharged from hospitals after shorter lengths of stay and in a poorer state of health" than before DRGs were in place. The report also noted that, with some exceptions, nursing home beds for early hospital discharge are not readily available. The study concludes, "We believe that the issues discussed in this report are sufficiently important to warrant HHS studies that will assess problems in access to and quality of post-hospital services supported by Medicare."

Finally, a survey conducted by the House Select Committee on Aging found that patients are leaving hospitals sicker and are requiring more post-hospital care since the enactment of the DRG system. Respondents to the survey, long term care ombudsmen in all 50 states, indicated by an overwhelming majority of 77 percent that patients have been leaving hospitals in sicker condition since the enactment of the DRG payment system. 71 percent of those responding also said that "more to many more" discharged patients require skilled nursing care after leaving hospitals.

If the SNF Medicare budget is frozen, thousands of elderly citizens will be tossed out into a vast "no-care zone", as SNF providers will refuse to participate because of the inadequacy of reimbursement in the face of sicker Medicare patients needing to be admitted. In a recent survey conducted in North Dakota, 22 of 39 nursing administrators with Medicare certified beds stated that they would be motivated to "drop out of the Medicare program" or "severely reduce Medicare services" if reimbursement were frozen at present levels.

QUALITY OF CARE WILL SUFFER

Already, inadequate reimbursement rates to SNF Medicare providers are unreasonably constraining the ability to deliver services. Despite the fact that Congress, in enacting the Section 223 cost limits, stated that the limits would apply "to a relatively quite small number of institutions" and only in "cases with extraordinary expenses", the Health Care Financing Administration (HCFA) has reported that 35 percent of the SNFs in the U.S. were hitting these limits in 1984. This percentage will, no doubt, be higher this year due to the higher cost of care needed by patients discharged under the hospital DRG system. If reimbursement rates are frozen, well over one half of the providers who continue to participate will be constrained by the limits. Such a broad application of Section 223 is clearly contrary to Congressional intent.

With so many providers being constrained by cost limits should a freeze be enacted, SNF reimbursement rates would essentially be flat. Such flat rate payments would create perverse incentives to deliver the lowest common denominator of care, seriously harming the health and well being of older Americans. As a General Accounting Office report stated, "Allowing a nursing home a fixed amount which does not consider the actual cost of operation may generate economic pressure on the nursing home (1) to reduce costs by sacrificing the quality of care provided or (2) to avoid incurring the increased costs necessary to improve the level or quality of care." The Urban Institute, well-known for its expertise in nursing home issues, has also stated, . . . "flat rate reimbursement tends to reward the sacrifice of quality in pursuit of lower costs." AAHA is adamantly opposed to a freeze which would effectively impose a flat rate payment system on SNF providers. Without question, beneficiaries will suffer most should this occur. The few providers who remain in the program will be forced to reduce staff in order to survive financially. The quality of care will surely decline as a result.

TOTAL MEDICARE SPENDING WILL INCREASE

If Congress is looking for methods to reduce the Federal deficit by reducing Medicare program expenditures, it is essential that a narrow view not be taken and that budgetary considerations be viewed in the context of total Medicare spending, not solely SNF Medicare spending. Expansion of the SNF Medicare benefit will almost surely result in reductions in total Medicare spending; primarily for three reasons. First, if hospitals are unable to discharge patients appropriately, they are likely to keep the patient in the acute setting until a bed for discharge becomes available. As the NCHSR study showed, such patients are likely to become outliers, resulting in Medicare payments far above the rates paid to nursing homes under the program. Second, the hospitals may discharge the patient to an alternative setting, such as a rehabilitation hospital or a rehabilitation unit within a hospital. Again, such facilities, which are exempt from the DRG system, are significantly more expensive than skilled nursing care, and are a cost inflating alternative. Finally, Medicare savings can be realized when the DRG system is rebased according to new cost data collected. Present rates were calculated on pre-DRG experience. If SNFs receive adequate reimbursement, and hospitals are able to quickly discharge patients to accessible skilled nursing facilities, hospital length of stay will be even more substantially reduced, resulting in concomitant budget savings upon recalculation of the rates. Alternatively, if access to post-hospital care is restricted, the new rebased rates will be unnecessarily high and fewer Medicare dollars will be saved.

In conclusion, senior citizens will face a crisis of epic proportions should Congress freeze the SNF Medicare budget. Providers would have no incentives to remain in the program, as even now, disincentives to participation are staggering. Thousands of older Americans would be tossed out into a vast no-care zone and government spending on health care would significantly increase. AAHA strongly urges Congress not to freeze the SNF Medicare budget. Elderly persons must be able to receive the services they need and have been promised.

Mr. Jacobs. Thank you.

Dr. Willging.

STATEMENT OF PAUL WILLGING, PH.D., DEPUTY EXECUTIVE VICE PRESIDENT, AMERICAN HEALTH CARE ASSOCIATION

Mr. Willging. With your permission, I will simply summarize my testimony.

I am Paul Willging, deputy executive vice president for the American Health Care Association, a trade association representing over 9,000 nursing homes in this country.

One might ask the question: If this industry does consume some $35 billion per year, why should the Congress be worried about a $5 million budget reduction with respect to Medicare? I think to a considerable extent, it is for the reasons Mr. Glaser suggested.

This cut, in terms of dollars is not all that significant. However, what is becoming an incredibly difficult problem is access with respect to nursing home care. Indeed the Medicare benefit does exist in the statute, but because of the failure by the industry to be able to participate in providing the services, that benefit essentially does not exist in many parts of the country.

It is important to note that problems to access preceded DRG's. But the DRG program has obviously impacted on and further compounded that problem. Of America's skilled nursing facilities eligible to participate in Medicare today, over one-third of them do not do so. In 20 States over the years between 1978 and 1982, there was a reduction in the number of beds available in skilled facilities to Medicare patients.

In a State such as Texas with 1,000 skilled nursing and intermediary care facilities, only 29 of them participate in the Medicare Program. In the entire State of Oklahoma, only one facility participates.

The Medicare long-term care benefit is one which is largely skewed. Only 9 percent of America's skilled nursing facilities provide 40 percent of the Medicare benefits. It is a benefit more appropriate to the high-volume patient population found in urban hospital based skilled nursing facilities. Indeed, over one-half of all facilities which participate in the Medicare skilled nursing facility program are in six States.

The problem of access can be traced to a variety of factors, including coverage determination, the nature of the reimbursement system and retroactive adjustments. A freeze put in place in terms of section 223 limits of reimbursement, without being accompanied by an attempt to address these other issues, will sorely test the industry's ability to provide even a minimal benefit to Medicare patients. Thirty-five percent of the Medicare certified skilled nursing facilities are already at or over the section 223 limits imposed. In those six States where most of the benefit is provided, 60 and 65 percent of the States are already impacted by that limit.

We clearly have a backup problem in hospitals. The report that HCFA has submitted or is about to submit projects nearly 1.5 million Medicare backup days in hospitals and 7.2 million Medicaid days if there is no increase in nursing home beds. The backup problem is serious and would be even more so with a freeze in this program.

We are suggesting that the Congress deal with the entire issue of reimbursement and look at the possibility of enacting a prospective reimbursement system for Medicare skilled nursing facilities. Access is a serious problem and it is time Congress looks at the entire Medicare Program.

Indeed while the Congress has fixed one part of the system, which has provided incentives to hospitals to discharge patients quicker, and some would argue sicker, it has not fixed the other side of the equation, that is providing incentives to other providers to accept those patients.

Until that is done, we have a very serious problem. A freeze will only compound it.

Thank you very much.

[The prepared statement follows:]

STATEMENT OF PAUL WILLGING, PH.D., DEPUTY EXECUTIVE VICE PRESIDENT, AMERICAN HEALTH CARE ASSOCIATION

Mr. Chairman and members of the subcommittee, I am Paul Willging, Deputy Executive Vice President of the American Health Care Association, the largest association representing America's for-profit and not-for-profit long term care providers.

AHCA's membership currently exceeds over 8,000 nursing homes, many of which provide skilled nursing facility services under the Medicare program.

My remarks today will focus primarily on the impact of the Administration's proposal to freeze reimbursement for Medicare beneficiaries in skilled nursing facilities at 1985 levels. In the context of the total Medicare budget proposals, the projected savings of $5 million may seem hardly worth discussing, but I submit to you that a freeze will greatly exacerbate an almost intolerable situation.

It may be good news to you that the hospital DRG payment system is achieving the objectives Congress set out. It is decreasing Medicare patients' lengths of stays in hospitals and discharging them earlier. But where are these patients to go? Presumably to nursing homes and home health agencies where they will complete their convalescence. Unfortunately, Congress has sorely neglected this part of the equation.

Precisely because DRGs are succeeding, nursing homes are being pressured to accept hospital discharge of more acutely ill patients. Yet we are faced with the paradox of declining participation by nursing homes and an even greater tightening of eligibility standards for beneficiaries. We need Congress' help to address this problem, not a reimbursement freeze to make it worse.

Fully 35 percent of the Medicare certified skilled nursing facilities are already at or over the Section 223 limits imposed, thus they can hardly be blamed if they choose to drop out of the program completely if the limits are frozen. The consequences of this action will fall directly on hospitalized Medicare patients.

The Medicare skilled nursing facility program has always been treated as the poor relation of acute care. It has either been ignored, misunderstood or manipulated. Ignored because attention has always focused on the program areas of greatest utilization and expenditures; misunderstood because nursing homes are so often thrown in with hospitals when cost-cutting actions are taken; and manipulated when HCFA undertakes through administrative measures to change eligibility determinations or other standards in an effort to cut utilization or deny benefits.

The cumulative effect of these insults upon the Medicare SNF program can best be appreciated if I give you a short snapshot with some telling data:

Access.—Between 1978 and 1982, nursing home dropouts from the Medicare program caused 20 states to experience a decrease in the number of certified beds per 1,000 beneficiaries. Eight states have fewer than 10 certified SNFs and a state like Texas, with over 1,000 nursing homes, has only 29 certified facilities. Oklahoma has, in the entire State, only one certified facility.

Costs.—In 1983 the average SNF Medicare per diem was $57.63. However, patient cost sharing is so high that the patient winds up paying more than the government after the 20th day because the copayment has always been tied to the inpatient hospital deductible. This bears no relationship at all to the cost of care in a skilled nursing facility.

Coverage.—At a time when Medicare patients are being discharged from hospitals "quicker and sicker," you would expect more admissions to SNFs and longer lengths of stay. Yet HCFA has chosen this time to make program changes such as eliminating the waiver of liability, to the extent that providers who have lost their waivers are experiencing a 25 percent decrease in Medicare patient days. Ostensibly, patients may have 100 days of covered SNF care, but for more than half of them their coverage lasts less than 20 days and nationally the SNF days of care per 1000 beneficiaries have actually decreased by 20 percent from 1973 to 1982.

There is no doubt as to who suffers as a result of all these policies: It is the vulnerable and sick Medicare beneficiaries, individuals who are ill-equipped to deal with inequities or problems in the system.

My hope is that I have painted a sufficiently bleak picture for you that you will want to do something about it. The solutions are not difficult, but they will require congressional recognition of the problem and action by the Ways and Means Committee among others, since this is a Medicare issue. Failing to take action now will not only cause anguish among thousands of Medicare beneficiaries, it will defeat efforts to cut expenditures.

What do we seek? Our first priority is the enactment of a prospective payment system for Medicare SNFs. Tomorrow the Senate Finance Committee will hold a hearing devoted to this topic alone. We solicit your interest, support and commitment for moving ahead on this important issue. It is our strong feeling that enactment of a prospective payment system for Medicare skilled nursing facilities will be the single greatest improvement that can be made in the program.

Secondly, we need your help in resolving the beneficiary coverage issues. We have been fortunate in working with a coalition of interested consumer and provider groups on the waiver of liability issue. As a group, we have met with HCFA requesting a postponement of the final regulations which would eliminate the waiver of liability until an assessment of the impact can be made. The coalition has also worked with the Senate and House Aging Committees and they have sent a joint letter to HHS Secretary Heckler posing a number of serious questions. As we have pointed out however, the waiver is only one part of a problem that includes other efforts by HCFA to ratchet down provider participation and patient utilization.

It is a mystery why the Department has pursued this short-sighted means to cost-savings when its own projections concerning hospital backup days portend a multibillion dollar expenditure by 1990 even if the number of nursing home beds remain constant. HHS has projected nearly 1½ million Medicare backup days in hospitals and nearly 8 million Medicaid days if there is no increase in nursing home beds. This translates into a minimum of $3.8 billion additional program expenditures which might grow even larger if the present policies are allowed to continue.

In conclusion, while we have come, just like everyone else today seeking special consideration in the proposed budget cuts, we hope we have succeeded in a little consciousness-raising on the whole set of problems confronting Medicare beneficiaries and their access to skilled nursing facilities.

Just as we have solicited your interest and assistance on prospective payment, we seek the same on behalf of beneficiaries in attempting to resolve these coverage issues. They have been more than a little troublesome in the past, but the advent of DRGs has raised these problems to another, more critical level of magnitude. The time has definitely come for the Congress and more specifically for your Committee, Mr. Chairman, to begin to address these issues.

American Health Care Association

PROPOSAL

Medicare SNF reimbursement

Three primary goals are to be achieved by a change in the SNF Medicare reimbursement methodology. The first is to improve patient access to care (particularly, heavy care patients). The second, but related, goal is to increase the participation level of long term providers in the Medicare program. The third goal is to provide a potential for significant cost containment in the long-run. All of these goals are intended to bring SNF reimbursement principles in line with the new hospital PPS and to anticipate and accommodate the consequences of PPS for the SNF industry.

Short-run

It is felt that for the short-run, a facility-based propsective system could be implemented almost immediately that would represent a significant step toward meeting these three primary goals. Prospective rates would be established annually on the basis of reported costs (indexed forward) of each facility. These prospective rates would be subject to a ceiling based on the median of reported costs in the geographic region (possibly, the current regions used for establishing 223 limits) plus a percentage as yet to be determined, but in the neighborhood of 10 to 15 percent. A median plus a percentage is suggested so that prospective rates will be limited by a reasonable, stable ceiling that would permit all efficiently operated facilities to have their costs reimbursed.

For facilities beneath some threshold level of participation in the Medicare program (say, 3,000 to 4,000 annual Medicare patient days), a prospective rate would be determined in each geographic region as a percentage of the geographic median rather than from the reported costs of each facility. These prospective flat rates should be set high enough (90 to 100 percent of the geographic ceiling) to provide an incentive for facilities to enter the Medicare program, increase their levels of participation, and rise above the threshold level of participation so that facility-specific rates can be established from their own costs. Facilities below the threshold would not have to submit Medicare cost reports at all, while the cost reports for those above the threshold level should be greatly simplified. The complexity for the cost report would be a function of the degree of specificity desired for the cost indexing process when setting facility-specific prospective rates.

In order to introduce continuing cost containment, an incentive payment should be made to all facilities above the threshold level of participation that is proportional to the difference between the prospective rate and the geographic ceiling. The size of the proportion must still be determined, but should be around .5 so that it is large enough to be meaningful to the provider and yet small enough to allow the government (the tax payer) to share meaningfully in the efficiencies introduced. Total incentive payments should also be limited to some percentage of the ceiling (say 10 percent) in order to prevent draconian cost containment which may negatively affect patient care.

A great deal of care must be exercised in the establishment of the prospective rate geographic ceilings, the threshold level of participation for geographic prospective payment, and the geographic prospective payment rate for those beneath the threshold. If current budgetary considerations become overriding so that these system parameters are set too low, the entire system design will have been frustrated and none of the three goals of improved patient access, increased provider participation, and long-run cost containment will be met.

The capital costs for each facility should initially be folded into its prospective rate and included in the computation of the ceiling for all the facilities in the geographic area, and the rate of return on equity replaced with a small fixed percentage add-on (say, 6 percent) to the sum of the other facility-specific capital costs (i.e., depreciation, interest, insurance, and taxes). In other words, a facility's capital costs plus 6 percent will be included in its prospective rate. This procedure will avoid the complexity of the equity computation and provide for equitable treatment of all facilities regardless of ownership. Since Medicare is such a small part of the total market, this procedure should not impact negatively on the debt/equity decisions of investors.

The only cost elements not to be covered by the prospective rate described above are ancillary costs (i.e., therapies, drugs, x-ray, and laboratory). These expenditure items are costly and highly variable as the patient-mix of the facility changes and cannot be adequately anticipated by a prospective flat rate. Therefore, these expenditure items should be reimbursed in a manner similar to that currently being used under Medicare Part B and should not be included in the computation of the ceilings, the below-threshold prospective flat rates, or the facility-specific prospective rates for those above the participation threshold.

Long-run

For the long-run, the short-run system could be modified in stages to produce a final system. These modifications are:

1. Introduce patient acuity into the reimbursement for those facilities above the participation threshold by converting part of the operating costs (namely, all nursing service costs plus raw food, activities, nursing supplies, and social/religious services) to a cost-based patient-related prospective payment system on the order of that currently being developed for Minnesota. Under this system, patient classes are assigned weights in each geographic region based on the values of the resources required in their care. The values of these weights are then established on a facility-by-facility basis from base year cost reports and indexed forward each year between base years. Patients are classified each month as part of the invoicing process and the facilities are paid accordingly. Verification of the invoices can be handled on a sample basis by the intermediary. Research is now underway by HCFA to establish the appropriate set of patient classes so that implementation may begin as soon as this reserach is completed.
2. Introduce a fair value rental system for capital costs using a gross rental concept. A rental paid on the current value of the total assets (land, building, fixed equipment, and movable equipment) is paid in lieu of all property costs (return on equity, depreciation, interest, insurance, and taxes). The rental rate should be based on historical money rates of return plus a risk premium, but should also consider the potential profit in the form of incentive payments from operating efficiencies. This element of the long-run system could be implemented as soon as agreement is reached on how the current value of the total asset is to be established.
3. In order to reinforce the incentive to provide access for heavy care patients, it may be necessary to retain the provision to pay for some or all of the ancillaries in a manner similar to that currently used in the Part B program.

U.S. Senate,
Special Committee on Aging,
Washington, DC.

Hon. Margaret M. Heckler,
Secretary, Department of Health and Human Services,
Washington, DC.

Dear Madam Secretary: On February 12, 1985, the Department of Health and Human Services published in the Federal Register proposed rules on the Medicare Waiver of Liability. Member of the Senate Committee on Aging and the House Select Committee on Aging have serious reservations about the impact of proposed regulatory changes on elderly Medicare beneficiaries.

As you are aware, the House Select Committee on Aging held a hearing in February on the impact of cost containment proposals on elderly beneficiaries. In addition, the Senate Special Committee on Aging received a preliminary report prepared by the General Accounting Office on the impact of hospital DRGs on post-hospital long term care services. Testimony from the hearing and preliminary results of the GAO study demonstrate that with increasing pressure on hospitals to discharge patients "quicker and sicker," more and more patients are seeking post-hospital nursing home and home health services. Given the increasing need for post-hospital care, we are deeply concerned that the Department's proposed regulatory changes will ultimately decrease the access of Medicare patients to the services they need, and also increase the number of coverage denials.

We commend the Department on having convened an internal task force to reconsider the proposed rule in light of concerns raised during the comment period. We fully agree that a range of issues must be addressed before the Department proceeds any further with implementation. Appended to this letter are questions which should be taken up by the task force and for which we request your written response by May 15, 1985. In addition, we would like to know the Department's timetable and plans for the task force and for implementing final regulations.

We look forward to your response and to working with you to resolve this important issue.

Sincerely,

JOHN HEINZ,
Chairman, Special Committee on Aging U.S. Senate.
JOHN GLENN,
Ranking Minority Member, Special Committee on Aging U.S. Senate.
EDWARD R. ROYBAL,
Chairman, Select Committee, on Aging U.S. House of Representatives.
MATTHEW J. RINALDO,
Ranking Minority Member, Select Committe on Aging U.S. House of Representatives.

WAIVER OF LIABILITY PROVISIONS UNDER SOCIAL SECURITY ACT

IMPACT ON BENEFICIARIES, PROVIDERS, AND PROGRAM COSTS

1. What is the estimated number of beneficiaries who would be denied access to hospital, nursing home and home health services if, in response to the waiver of liability ruling imposed, providers choose to withdraw from the Medicare program or tighten their critieria for accepting potential Medicare patients?

2. During the 1984 and 1985, what was the total number of Medicare claims submitted for hospital, nursing home and home health reimbursement? What number of these were denied and of those denied, what number were appealed? What was the denial rate and rate of reversal in each year? What was the dollar value of post-hospital Medicare benefits denied after final appeal during each year?

COSTS AND COST SAVINGS

1. What is the potential increase in costs to the beneficiary and to Medicaid under the proposed ruling as, with decreasing access to Medicare services, more patients enter nursing homes as private pay patients and subsequently spend down to Medicaid?

2. What is the estimated additional cost that would be incurred by Medicare providers annually as a result of denied claims if the proposed waiver of liability ruling were imposed?

3. Has the Department estimated the cost savings under the proposed ruling that includes the costs associated with case reviews, reconsiderations and appeals? What proportion of the estimated savings would result from providers withdrawing from the Medicare program?

PROCEDURES AND INCENTIVES FOR INTERMEDIARIES AND PROVIDERS

1. What standards and criteria for claims review are in place or being developed to provide guidance to providers and intermediaries to ensure that beneficiary claims are fairly and consistantly reviewed within and among states?

2. If the proposed rule is imposed, how would HCFA assure that an increase in the rate of denial for legitimate claims would not result, assuming that providers will tend to deny cases in which there is any doubt of coverage? What protections would be built in to protect the beneficiary in such cases?

3. What, if any, incentives exist to discourage high reversal rates in client appeals that might be associated with particular intermediaries? Is a provider's reversal rate considered in determining whether a pattern of inappropriate utilization exists?

COMMENT PERIOD

Please explain the necessity of imposing a 30-day comment period for a rule that has taken over two years to develop. This shortened time period imposes difficulties on individuals and organizations wanting to become fully informed and to fully assess the impact of proposed rulings.

LETTER SENT TO WAYS AND MEANS HEALTH SUBCOMMITTEE

MARCH 11, 1985.

Hon. ANDREW JACOBS, Jr.,
Longworth House Office Building,
Washington, DC.

DEAR CONGRESSMAN JACOBS: This letter is written on behalf of a coalition of health care consumers, providers, and State Medicaid agencies, organized to request your assistance in persuading the Administration to delay and eventually retract its proposed rule to eliminate the Medicare waiver of liability (Federal Register, February 12, 1985, pages 5787–5792). The proposed rule eliminates the favorable presumption for Medicare coverage. This presumption provides relief to a beneficiary or provider who acted in "good faith" in accepting and providing services, later found to be (a) not reasonable or necessary for disgnosis/treatment of illness/injury or to improve functioning of a malformed body member, or (b) custodial carc. The proposed rule, if implemented, will result in decreased availability of Medicare long term care services to sick and infirmed elderly Medicare beneficiaries.

The coalition solicits your assistance to (1) have the 30 day comment period for the rule extended, and (2) have rule retracted.

The 30 day comment period ends March 14, 1985. This does not allow sufficient time to assess the impact of the proposed rule on beneficiaries and long term care services. Unlike some rules, this rule was not drafted with input from those individuals and organizations affected by it. Indeed, the content and extent of the rule was unexpected. The extensive nature of the rule precludes our being able to research and respond to its many issues within a 30 day comment period. We specificially ask that you contact the HCFA Administrator and request that the comment period be extended an additional 30 days so that providers and consumers will be able to develop substantive comments on the impact of the rule.

Background material and the coalition's opposition to it has been developed and is attached. You will see that it includes background information about the waiver of liability, general concerns of the coalition and specific concerns of each of the constituencies represented in the coalition.

We hope you will oppose hasty action by HCFA. The members of our coalition, who are listed below, would be pleased to provide any further information you might desire on this issue. We will be in touch with you during the week ahead to see if further discussions can be arranged.

Thank you for your attention to this critical matter. We look forward to discussing this issue with you personally.

Sincerely,

RICHARD N. JENSEN,
American Public Welfare Association, and 11 others.

HEALTH CARE CONSUMERS AND PROVIDERS BRIEFING PAPER ON HCFA'S PROPOSED ELIMINATION OF THE MEDICARE WAIVER LIABILITY

BACKGROUND

The Medicare waiver of liability is authorized by Sec. 213(a) of the Social Security Amendments of 1972. The purpose of the waiver is to provide relief to a beneficiary or provider who acted in good faith in accepting the providing services later found to be (a) not reasonable or necessary for diagnosis/treatment of illness/injury or to improve functioning of a malformed body member, or (b) custodial care.

In order to determine the providers liability, a favorable presumption is given where a provider has demonstrated "ability" to distinguish between covered and non-covered items. The provider can earn this favorable presumption if its "denial rate" does not exceed a certain percentage (2½% for hospital or home health agency, 5% for a skilled nursing facility). If the number of days of care determined by the provider to be covered and billed to the intermediary, but then denied by the intermediary, amount to fewer than 2½% (HHAs, hospitals) or 5% (SNFs) of the total of all covered Medicare days, the provider has satisfied the denial rate criterion and is entitled to the favorable presumption. If the denial rate exceeds the given percentage, the provider loses its favorable presumption for the quarter.

On February 12, 1985, HCFA published "Medicare Program; Procedures for Determining Whether Providers, Practitioners, or Other Suppliers of Services Are Liable for Certain Noncovered Services" in the Federal Register (pp. 5787-5792). The proposed rule would eliminate the favorable presumption for providers and shift to a case by case review system. The proposed rule will force providers to absorb the cost of services provided in good faith but denied Medicare coverage. It will result in providers limiting their provision of services to only those which are sure to be covered by Medicare.

CONCERN

The overriding concern of the coalition members is that elimination of the waiver of liability will seriously restrict the availability of care and services needed by some Medicare beneficiaries.

As noted before, our coalition is comprised of representatives of varied consumer, providers and State Medicaid agencies. As with any extensive regulatory action the members have both mutual and exclusive concerns. Below is a summary of the concerns.

BENEFICIARIES CONCERNS

Medicare beneficiaries are concerned that the elimination of the waiver of liability will reduce their access to health services and increase their out of pocket costs for these services because providers will be discouraged from acccepting patients for all but those services sure to be covered.

Under current regulations, beneficiaries are adversely affected by many policies and practices. For example, eligibility for skilled nursing facility benefits is not uniformly granted by fiscal intermediaries. The hospital prospective payment system is increasing the demand for long term care services, which, in many communities, are not always readily available or covered by Medicare. The prospect of more restrictive payment policy to hospitals, SNFs, and home health agencies will limit providers' fiscal flexibility in an already tight system.

It would be counterproductive and questionable health policy for HCFA to eliminate the favorable presumption for Medicare coverage at a time when the Medicare program is in such a state of flux. It is the beneficiaries who will be harmed the most by such a change, both in terms of access to services and out of pocket expenses.

The problems that beneficiaries face in the current system can only be exacerbated by the proposed regulation. Beneficiaries fear that pressure on providers will result in their refusing to take risks of nonpayment and therefore, not accept beneficiaries as Medicare patients. In fact, if providers perceive that Medicare has become too burdensome, current practice indicates that some will cease to participate in the program. If services which should be covered by Medicare are not available, beneficiaries will be burdened with the high cost of health care. Eventually some will deny themselves essential services or exhaust their private resources and be forced onto the already strained Medicaid roles.

GENERAL PROVIDER CONCERNS

Providers oppose the proposed elimination of the current waiver of liability for Medicare providers and consumers for the following reasons:

1. The proposed rule violates the Congressional intent of the 1972 Social Security Amendments which authorized the waiver of liabilty to protect beneficiaries and providers. HCRA's contention that Sec. 145 of TEFRA authorizes an elimination is incorrect. The TEFRA language clearly states that payment for services can be excluded only if the provider has been notified tht a pattern of inappropriate utilization has occurred in the past and the provider has been allowed a reasonable time to correct the inappropriate utilization. The language does not eliminate the waiver established in 1972 but directs HCFA to develop a better system for identifying inappropriate utilization.
2. The proposed rule erroneously assumes that regulations, manual guidelines, HCFA and intermediary directives and memos clearly and consistently convey coverage policy in advance of rendering care. In reality, Medicare coverage policy contains more gray areas than black and white, and is more subjective than objective.
3. In the absence of a favorable presumption, providers will have no recourse but to restrict patient access to Medicare services, even where there is a reasonable belief the care is covered.

4. The proposed rule will burden sick and infirmed Medicare beneficiaries who will have to appeal denial decisions.

5. The case by case review will result in paperwork burdens, slowdowns in claims processing and provider cash flow problems.

6. The proposed rule does not properly address the impact on the public, businesses, and intermediaries.

HOME HEALTH AGENCIES

Home health agencies share the general concerns noted in the above section. In addition, the agencies have specific concerns stemming from current problems with fiscal intermediaries not implementing the program consistently.

By HCFA's own admission, the key terms in coverage determinations for home health are highly subjective, making it virtually impossible for a provider or beneficiary to be 100 percent certain 100 percent of the time in reaching coverage decisions. Two examples of highly subjective terms unique to home care are "intermittent" and "homebound". Inconsistent application of coverage by intermediaries inhibits the provider's ability to know what is and what is not covered and adds to the need for a cushion of protection within reason.

Home health providers doubt it is possible for coverage guidelines to be developed which will provide absolute predictability of coverage and will eliminate their risk or retroactive denial.

Home health care patients' needs for services vary. For example, an elderly patient with a colostomy, discharged from the hospital to home alone, may need home health aide services. A similar patient discharged home to an extended family may not need aide services. A third similar patient discharged to a senior citizens home may need some, but not many aide services. It would be impossible to write a guideline which considers all situations in which the aide services would not be covered.

Another problem unique to home health agencies is the soon to be implemented move from 47 to 10 fiscal intermediaries. This move will cause confusion, at least at the start. The ten intermediaries will have to prepare their staffs to process the claims. Until reviewers acquire necessary experience there will be mistakes made, some nonservices will be covered, some services that should be covered will be denied, and inaccurate notices of inappropriate utilization will be issued. The chain effect will be increased appeals and administrative judicial decision. In addition to general confusion, this will cause cash flow problems while these cases are on appeal. The cushion provided by the waiver will be needed to ease the inevitable problems which will result from the switchover.

NURSING HOMES

Nursing home provider experience indicates that the Medicare coverage system does not work smoothly at present. Providers are subject to inconsistency among intermediaries in coverage decisions and even within a single intermediary.

These inconsistencies effectively force providers, in order to protect themselves from denial of payment, to tell beneficiaries that needed services that might, in fact, be covered, are not covered because they believe that the intermediary will deny coverage. The result is that beneficiaries are denied coverage—not only be intermediaries, but by facilities themselves, of services that they are entitled to receive.

We are concerned that the proposed revision will create pressure on providers to increase this practice, resulting in increased numbers of consumers not receiving services they should receive.

In addition, we believe that if the proposed rule is implemented many providers will cease to participate in the Medicare program resulting in less accessibility to services by beneficiaries.

Since the advent of hospital prospective payment systems, long term care provider organizations have encouraged their members to work cooperatively with hospitals to facilitate early discharges and patient transfers. The proposed rule will pose a serious set back to such cooperative efforts because facilities will be reluctant to accept Medicare cases.

Hospital prospective payment has added another problem to the nursing home Medicare program in that in attempting to discharge patients as soon as possible, weekend admissions are becoming more frequent. Often the nursing home staff responsible of making preliminary determinations—usually the director of nursing service—is not present. Without a waiver of liability on which to fall back, nursing homes will be forced to deny these weekend admissions.

These problems will inevitably lead to higher, not lower costs, as implied by the regulatory proposal. Costs will be found in increased case loads of administrative law judges as more consumers appeal denials. Also, with fewer nursing homes participating in Medicare and those participating accepting a smaller number of Medicare patients, patients will either remain in hospitals, becoming outliers or will be transferred to costly rehabilitation hospitals. We believe that lack or access to the SNF Medicare benefit will greatly increase Medicare costs.

A central problem with the proposed rule for nursing homes is the provision that facilities will be denied payment if they have been notified of a pattern of inappropriate utilization. In our experience, each nursing home patient presents a new, unique picture. For example, two patients may be discharged from a hospital with a primary diagnosis of hip fracture and a hospital stay of seven days. While their hospital courses may have progressed relatively similarly, when they enter a nursing home, the idiosyncracies of their cases will be apparent or magnified. While one patient progresses well, another's progress may be hampered by such factors as respiratory problems, dementia, diabetes or nutritional problems. According to the proposal, a facility could be denied payment if, in the past, "similar" cases had been denied. If the first case of hip fracture described above was denied, it could be interpreted as being similar to the second. However, in fact, they are not similar at all. We believe a definition of similar cases will be impossible to develop and to implement, therefore, making the basic concept of the proposed rule invalid.

Another problem specific to nursing home relates to the low volume of Medicare cases. Medicare patients constitute approximately 2 percent of a long term care facility's population. This means that facilities, attending physicians and intermediaries have limited experience with the program. For facilities, this means that their staff has a small frame of reference with which to predict Medicare coverage. For physicians, this means that their knowledge or documentation needs is insufficient. For intermediaries, this means that inconsistency among reviews and even by the same reviewer should be expected.

In summary, we believe that nursing home participation in Medicare will be greatly reduced and that consumer access to the SNF benefit will be diminished if the proposal goes forward.

HOSPITALS

Physicians prescribe Medicare services for hospitalized patients. The practice of medicine is not governed by a set of hard and fast rules, but by the judgment of individual practitioners treating individual patients under conditions of considerable uncertainty. The waiver of liability is needed to protect competent providers from a retroactive denial of payment for services rendered in good faith to Medicare beneficiaries.

Because there will always be uncertainty in making medical decisions, there is and always will be some margin of "erroneous" decisions. The waiver was enacted as a statutory acknowledgement that not all coverage decisions are clearcut. No tolerance for uncertainty creates a pressure to refuse admission when the need is uncertain. These rules would restrict admissions which may be necessary. That would not be the case if all medical decisions were absolutely clear, or if HCFA insured appropriate handling of medical necessity decisions on cases where definitive coverage policy is lacking or definitive criteria are invalid. In the absence of these assurances, the Medicare program must provide the favorable presumption as a margin of uncertainty in order to firmly establish the priority of the beneficiary's needs over the program's desire to avoid paying for noncovered services.

Hospitals are also under pressure to discharge patients quicker. Uncertainty of the availability of extended SNF or home care may mandate the hospitals to retain these patients at a higher cost.

CONCLUSION

Elimination of the favorable presumption of the waiver of liability will decrease long term care services at a time when the population is aging and the need for long term care is increasing.

Mr. JACOBS. Thank you, gentlemen. I think you overlook something. I do not see how we can afford to finance the killing of people in other countries and not waste a lot of money curing people in this country.

Mr. Gradison.

Mr. GRADISON. I have no questions.

Mr. JACOBS. Mr. Donnelly.

Mr. **Donnelly**. I have no questions.

Mr. **Jacobs**. Mr. Gregg.

Mr. **Gregg**. I was just wondering, are you seeing an increase in hospitals going into Medicare skilled nursing services as a result of early discharge under the PPS program?

Mr. **Glaser**. Being from New York, we are not as yet under the DRG system. But in addressing the issue with my colleagues in other States that are impacted by the DRG system, yes, the underutilizaton of hospital beds seems to be pushing hospitals into skilled nursing activities.

Mr. **Gregg**. Is it logical that we should go to some sort of PPS system in skilled nursing facilities?

Mr. **Willging**. I think, quite frankly, that is exactly what we have to do. I think implementation of such a system will go a long way in curing the access problems and deal with the question of flexibility and cost containment. The time is right to do it. It will not be a panacea, but again, it will begin to address some of the access problems.

Mr. **Bedlin**. If one wants to promote cost containment, I do not believe that shifting to hospital-based nursing facilities is the answer. If you look at the data, hospital-based nursing facilities cost 100 percent more than free-standing nursing facilities for essentially the same services.

Mr. **Gregg**. I guess my concern is if we have a system that is driving the patient out of hospitals, it is logical that hospitals are going to go into skilled nursing facility services because they are going to get higher reimbursement under the system. They will get the PPS rate plus the reasonable cost of providing the skilled nursing facility services. So you have sort of got a leak in the boat, so to say.

Mr. **Glaser**. It runs a little deeper than that. It is a quality issue that has to be looked at. In my facility, where we provided 28,000 days of care last year, I lost $800,000 in treating Medicare patients because of the 223 limits. I am losing about $28 per day in caring for Medicare patients. And that is a little bit outrageous.

Could you imagine what a freeze would do to my ability to continue serving this kind of population?

Mr. **Gregg**. Well, that would eat up a lot of the $5 million.

Mr. **Jacobs**. Are there any further questions for the panel?

We thank you for coming in.

The next panel consists of Mr. William O'Neil, Mr. Sanford Linden, Ms. Joan Buddi, and Ms. Margaret J. Cushman. If you would come forward and identify your organization.

You all know the rules. Turn in your statements and proceed in your own manner. And I suppose we should proceed as listed on the schedule.

STATEMENT OF WILLIAM C. O'NEIL, JR., PRESIDENT, INTERNATIONAL CLINICAL LABORATORIES, NASHVILLE, TN, AND PRESIDENT, AMERICAN CLINICAL LABORATORY ASSOCIATION, ACCOMPANIED BY H. ROBERT HALPER, GENERAL COUNSEL

Mr. **O'Neil**. Thank you for the opportunity to testify this morning. My name is William O'Neil, and I am president of the American Clinical Laboratory Association, a trade association of federally regulated, independent laboratories. All of ACLA's members have extensive experience in providing services to Medicare beneficiaries.

At the outset, I cannot overstate our opposition to the proposal to freeze reimbursement levels for clinical laboratory services provided to Medicare patients. Laboratories have already sustained an overall reduction of 40 percent of the amounts they previously received in payment for clinical testing services provided to ambulatory Medicare beneficiaries as a result of the enactment of the Deficit Reduction Act in 1984.

Thus, just last July the Health Care Financing Administration established new fee schedules set at 60 percent of the program's prior payment levels, causing a revolutionary change in the way Medicare reimburses laboratories.

As a result of this change, ACLA members report that they are receiving substantially less for providing testing services to Medicare patients than they received before this reduction. Our written statement contains the statistics.

Despite these reductions, ACLA did not oppose the changes mandated by the Deficit Reduction Act for several reasons. First, we recognized that we had to contribute both to the Nation's deficit-reduction efforts and to positive changes in the health care system.

Second, as Congress was attentive to the problems that laboratories might experience as a result of the large reductions in reimbursement levels, the Deficit Reduction Act promised an annual adjustment in these reduced reimbursement rates based on the consumer price index. ACLA relied on this promise. Now, only 9 months later, the administration proposes that these adjustments be eliminated. After so significantly reducing reimbursement levels only year ago, this proposed freeze is asking clinical laboratories to bear too heavy a burden.

Third, in supporting the 1984 Deficit Reduction Act, ACLA recognized that the legislation continued provisions promising benefits to laboratories that would, if implemented, blunt some of the sting of the reimbursement reductions. Thus the act called for reduced billing, payment and collection burdens to lower the costs associated with these functions that are now incurred by both laboratories and the program. As a partial offset for the large reimbursement reductions, ACLA viewed these directives as the quid pro quo for not opposing the Deficit Reduction Act because of the potential for reduced administrative costs. However, 9 months have passed and nothing has yet happened; no simplifications have occurred. To eliminate the promised annual update of the fee schedule without any of the offsetting benefit that the act was supposed to guarantee is to ask too much. Stated simply, laboratories are being squeezed, and the pinch is too tight.

Historically laboratory charges have not increased as quickly as the charges of other members of the health care industry as our written statement demonstrates. In the face of the unfulfilled promises of the Deficit Reduction Act, it is unfair to ask laboratories to forego the guarantee of a 4.01-percent reimbursement increase, particularly in light of the reductions we have already experienced.

To summarize, ACLA opposes the fee freeze since we have already experienced a substantial and significant reduction. The fee freeze would not only be unfair but damaging to the laboratory industry and its ability to provide responsive, high-quality testing services for Medicare patients.

Thank you very much.

[The prepared statement follows:]

STATEMENT OF WILLIAM C. O'NEIL, JR., PRESIDENT, AMERICAN CLINICAL LABORATORY ASSOCIATION

My name is William C. O'Neil, and I am President of the American Clinical Laboratory Association, a trade association of federally regulated independent laboratories. All of ACLA's members are certified pursuant to the Medicare Conditions for Coverage of Services of Independent Laboratories and therefore have extensive experience in providing services to Medicare beneficiaries. Before I begin my substantive remarks, I want to thank the Committee for inviting me to testify on the widsom of freezing Medicare payments for clinical laboratory testing services provided to ambulatory patients. ACLA will submit additional, more extensive written testimony outlining its views before the Committee's April 30th deadline, and we request that that written testimony be made a part of the record.

At the outset, I cannot overstate ACLA's opposition to this proposal. Laboratories have already sustained an overall reduction of 40% of the amounts they previously received from the Medicare Program in payment for testing services provided to ambulatory Medicare beneficiaries as a result of enactment of the Deficit Reduction Act of 1984. Thus, last July, pursuant to Section 2303 of that statute, the Health Care Financing Administration established fee schedules set at 60% (or in the case of hospital outpatient testing, 62%) of the Program's prior maximum payment levels ("prevailing charges).

Although the President did not sign the Deficit Reduction Act into law until July 18, 1984, the Health Care Financing Administration retroactively implemented the fee schedule reimbursement methodology, along with its reduced reimbursement rates, and applied them to all clinical testing services provided to ambulatory beneficiaries on or after July 1, 1984. As a result, HCFA instructed carriers, the Medicare contractors charged with the responsibility of determining reimbursement levels and making payments, to withhold payment to laboratories until fee schedule levels had been calculated. Thus, the decision to implement the fee schedule reimbursement methodology retroactively caused considerable disruption to the industry as laboratories did not receive Medicare payments for a number of months thereafter. In addition, laboratories are still adjusting to the reduced payment rates.

Congress was not insensitive to the problems that laboratories might experience as a result of the reduction in reimbursement levels. Recognizing the severity of this reimbursement reduction and the fact that so long as there is any inflation laboratories will experience increasing costs, the Deficit Reduction Act promised an annual adjustment in these reduced reimbursement rates to reflect the changes in the Consumer Price Index. Now, only nine months later, the President proposes that this annual update should be repealed, at least for the period beginning July 1, 1985 and ending either on June 30, 1986 or September 30, 1986. To repeal this adjustment for that period, after so significantly reducing reimbursement levels less than one year ago, is to ask laboratories to bear an unfairly heavy burden in this nation's deficit reduction efforts. While we recognize the urgency of reducing the deficit and indeed actively supported enactment of the Deficit Reduction Act as our industry's contribution to reducing that deficit, we feel that enough is enough.

In supporting the 1984 Deficit Reduction Act, ACLA was cognizant that laboratories would sustain reduced Medicare payments. However, ACLA recognized that the laboratory payment provisions contained in the Act promised certain benefits to laboratories that would, if implemented, blunt some of the sting of the reimbursement reductions. Thus, the Act directed HCFA to simplify the Medicare billing, payment and collection process in an effort to reduce the costs incurred by both laboratories and the Program that are associated with these functions. HCFA had previously conceded that unnecessary costs attend these functions. In a report issued by an intra-agency HCFA laboratory task force on February 15, 1984,[1] the task force ac-

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[1] This task force report, which is appended hereto, formed the basis for the laboratory payment provisions of the Deficit Reduction Act. Indeed, the task force's recommendations were es-

Continued

knowledged that HCFA's billing, collection and payment procedures could and should be simplified, stating:

> The Task Force believes that the final step needed to assure program and beneficiary savings is extensive effort to simplify claims processing requirements, particularly for independent laboratories. Among the changes proposed by the Task Force are:
>
> (1) deletion of the requirement for a diagnosis on independent laboratory claims, as long as the name of the referring physician is included on the bill;
>
> (2) requiring carriers to accept and process periodic billings for all of a laboratory's Medicare patients rather than requiring individual claims for each patient;
>
> (3) limiting the patient-specific information required to the minimum that will permit identification of the beneficiary;
>
> (4) instituting prompt payment practices; and
>
> (5) requiring carriers to provide, along with the explanation of Medicare benefit, the laboratory's invoice or specimen accession number to facilitate its reconciliation of Medicare payments with Medicare billings.

Report of Laboratory Task Force, Page 25

The laboratory payment provisions of the Deficit Reduction Act incorporated these recommendations by requiring:

"The Secretary [to] simplify the procedures . . . with respect to claims and payments for clinical laboratory tests so as to reduce unnecessary paperwork while assuring that sufficient information is supplied to identify instances of fraud and abuse."[2]

Section 2303(h)

The Conference Committee Report added that this "provision does not require patient diagnosis to appear on bills." Deficit Reduction Act of 1984, Cong. Rpt. 98-861, 98th Cong., 2d Sess., p. 1308.

ACLA viewed these directives as the quid pro quo for not opposing the Deficit Reduction Act because of its call for reduced reimbursement levels. However, although ACLA has been working with HCFA since last July in an effort to obtain the mandated simplification nothing has yet happened. None of the task force's simplification recommendations have been implemented, and a number of carriers continue to require laboratories to supply diagnosis information.[3] Thus, ACLA's hopes have gone unrealized that the reduced reimbursement levels would be coupled with claims processing simplifications that would reduce both laboratory and programmatic administrative costs. To eliminate the promised annual update of the fee schedule in the face of the unfulfilled promise of billing simplifications is to tax laboratories with still more reimbursement cuts (the freeze in reality amounts to a reimbursement reduction of 4.1%, the amount that the fee schedule would have been increased on July 1 in the absence of the President's budget proposal) without any of the offsetting benefits that the Deficit Reduction Act was supposed to guarantee. Stated simply, laboratories are being squeezed and the pinch is too tight.

The squeeze that independent laboratories are being asked to sustain is even more crippling because laboratory charges have not increased as quickly as the charges of other members of the health care industry. Indeed, the charges of independent lab-

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sentially incorporated in toto in the Act. The task force began studying the industry and the relationship between the industry and Medicare in October 1982. Thus, its report and the recommendations contained therein are the culmination of 17 months of study, investigation, on-site visits and thought. It is the best exposition of the laboratory industry that ACLA has seen.

[2] The Task Force recognized the importance of detection of fraud and abuse and made the following observation: "While the Program necessarily has to concern itself with identifying and eliminating instances of fraud and abuse and protecting the overall fiscal integrity of the Program, the Task Force believes that instances of fraud and abuse should be viewed as the exception rather than the rule. Billing simplifications need not undermine the Program's ability to eliminate questionable practices. Rather they might well eliminate some of the underlying reasons for such practices by reducing suppliers' costs of doing business with the Medicare Program. Additionally, they represent a good faith effort to rationalize Program payment in a manner that is to all parties' advantage. From this perspective, it may be useful to handle audit and program validation efforts by periodic sampling and linking of laboratory and physician claims processing procedures to try to identify every questionable claim for diagnostic testing." Report of Laboratory Task Force, p. 26.

[3] ACLA does not challenge HCFA's good faith. HCFA officials have met frequently with ACLA representatives to achieve simplification. However, despite good intentions, the system continues to be unnecessarily cumbersome, burdensome and expensive.

oratories, when compared with other laboratory providers, have escalated considerably less rapidly. Thus, the task force report revealed the following statistics:

Diagnostic laboratory charges to Medicare—average annual compound growth rate 1976-80

Specialty	*Percent*
Internal Medicine	7.6
Independent Labs	6.3
General Practice	6.7
Clinic	7.0
Cardiovascular	15.3
Family Practice	6.4
All Others	12.8

Report of Laboratory Task Force, page 20

As these statistics demonstrate, the price to Medicare of laboratory services, in general, escalated considerably less sharply during the 1976-80 period than did the amounts Medicare paid for other services. And, of the specialities seeking payment from Medicare for laboratory testing services, independent laboratories escalated the least, rising a mere 6.3%. Because Medicare payments to independent laboratories have remained relatively constant, they are likely to have difficulty incorporating a fee freeze.

Even without the proposed freeze, ACLA members report that they are receiving substantially less from Medicare for services than they did before the 40% reduction, as the following chart reveals:

Largest reduction experienced by ACLA members

Test	*Reduction*
CBC	$5.80
Platelet Count	5.85
Sodium	5.90
Potassium	6.52
Glucose	11.19
Cholesterol	11.00
T-4	8.75
Urinalylsis	2.50
Digoxin	19.50
Prothrombin Time	4.80
SMA-12	9.75
SMAC	12.33
SMAC-20	13.65
Tryglycerides	9.70
Electrolytes	10.00
Serum Iron	9.00
VDRL/RPR	7.13
BUN	3.95
Calcium	7.25
Uric Acid	3.55

These reductions were calculated by taking each laboratory's payments from Medicare during May and June of 1984 (before imposition of the fee schedule), adding the 20% that laboratories had received from co-insurance payments and subtracting from that figure current fee schedule amounts. To ask laboratories to forego the 4.1% is to increase the impact of these already substantial reductions.[4]

The effects of the proposed laboratory fee freeze, in light of the recent substantial reimbursement reductions that laboratories have experienced, are obvious. The proposal threatens the ability of laboratories to continue providing high quality services to Medicare beneficiaries. These results are so apparent that there is no need to dwell on them.

While ACLA strongly opposes the proposed fee freeze, we have been informed by HCFA officials that the legislation implementing the President's budget will also propose an elimination of those provisions of the Deficit Reduction Act that would end the fee schedule reimbursement methodology for hospital outpatient clinical laboratory testing services on July 1, 1987. We strongly favor repeal of this sunsetting provision contained in Section 2302(d) of the Act. ACLA supported the fee schedule reimbursement methodology contained within the Deficit Reduction Act and opposed the sunsetting provisions, as we, like the Administration, have favored adoption of uniform laws, regulations and rules applicable to all laboratories, regardless of the laboratory's site. Thus, ACLA has consistently supported site-neutral reimbursement policies that do not differentiate between hospital, independent or physicians' office laboratories. We see no reason for treating hospital outpatient testing differently from testing services provided to Medicare ambulatory patients by independent or physicians' office laboratories. We are therefore gratified by this portion of the President's proposal. Moreover, as the bulk of the savings that will be experienced as a result of the application of the fee schedule reimbursement methodology to hospital outpatient testing will occur in the years that follow 1987, it makes no sense to require Congress to reauthorize application of the fee schedule reimbursement methodology to hospital outpatient testing in 1987.

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[4] That these reductions are substantial is confirmed when one recognizes that the levels of payment that are authorized by the fee schedules are small dollar amounts. For example, one of the fee schedules pays $7.20 for a CBC. Thus, a reduction of $5.80 to a price of $7.20 is significant.

Again, let me thank you for the opportunity to participate in this hearing. ACLA would be pleased to work closely with you as you develop a Committee response to the budget package. Thank you.

REPORT OF LABORATORY TASK FORCE, DEPARTMENT OF HEALTH AND HUMAN SERVICES, HEALTH CARE FINANCING ADMINISTRATION, BUREAU OF PROGRAM OPERATIONS

INTRODUCTION

Over the past few years, Medicare Part B and Medicaid reimbursement for diagnostic laboratory services has been the subject of considerable attention and criticism. Much of this criticism has addressed the pricing policies of independent laboratories participating in the Medicare program, as well as physician mark-ups of independent laboratory prices, and reimbursement differentials between Medicare and Medicaid for identical services. Critics have also identified numerous problems with Medicare carriers' and Medicaid fiscal agents' processing of claims for laboratory tests (e.g., duplicate payments, payment for more expensive tests than were ordered, payment for groups of tests billed as a panel or profile).

In light of concern that some of these problems persisted after various legislative and administrative attempts to remedy them, HCFA in October 1982 convened a Task Force to examine reforming reimbursement of diagnostic laboratory services. These services, which are performed in hospitals, physicians' offices, and independent laboratories will comprise 7.9 percent of total benefits under Part B in FY 1984 ($1.6 billion of $15.6 billion). Because charges and reimbursement for identical services have tended to vary as a function of who bills Medicare, some investigators have called for changes in HCFA's reimbursement policy. The Task Force was composed of representatives of HCFA's legislation, policy, operations and quality assurance staffs, as well as representatives of the Inspector General and the Assistant Secretaries for Management and Budget and for Planning and Evaluation. Over the course of the past year, the Task Force has met with representatives of the American Clinical Laboratory Association (ACLA) and Medicare carriers, and has visited several independent laboratories, including local laboratories and national laboratories or chains. In addition, members of the Task Force reviewed current policies for Medicare reimbursement of laboratory services and documents evaluating the effects of such policies, as well as critiques of current practices.

Two features of Medicare's reimbursement practices were particularly germane in shaping the Task Force's agenda. In a recent report,[1] the Office of the Inspector General (OIG) sharply criticized both the practice of independent laboratories of charging Medicare more than they charge physicians for the same test and Medicare's recognition of these higher charges in the computation of reasonable charge allowances and prevailing charge profiles. Noting that independent laboratories have responded to charges of "price discrimination" by differentiating between the costs of account billings rendered to physicians and individual bills rendered to patients and their third-party insurers, the OIG recommended that HCFA seek legislative authority to "(1) allow laboratories a nominal fee for the extra costs they incur in billing Medicare and Medicaid, and (2) prohibit laboratories from charging Medicare beneficiaries more than they charge physicians."

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[1] Office of the Inspector General, Department of Health and Human Services, "Despite Years of Attention: Clinical Laboratory Tests Still Cost Medicaid/Medicare Too Much," March 8, 1982.

The initial charter of the Task Force was to focus on ways in which Medicare claims processing requirements could be streamlined in order to reduce billing costs incurred by independent laboratories in dealing with the Medicare program. It became rapidly apparent from our early meetings, however, that this issue was integrally tied to an understanding of the market for diagnostic laboratory tests and the broader issue of how to establish appropriate reimbursement levels for laboratory testing services. Consequently, it was our effort to obtain background data on the laboratory testing market that broadened our focus to the overall question of Medicare reimbursement policy for diagnostic laboratory tests.

In the course of its deliberations, the Task Force also kept abreast of legislative proposals being considered by the Congress in the area of laboratory services and attempted to evaluate ways in which such changes would respond to the concerns being addressed by the Task Force.

The Task Force presents the following final package of recommendations for your consideration:

1. HCFA should establish a fee schedule as the basis of payment for Medicare reimbursement of all diagnostic laboratory services. This fee schedule should apply equally to tests performed in independent laboratories, physicians' offices, and in hospitals for outpatients and physicians' referrals.
2. The initial fee schedule should be established as a fixed percentage (i.e., 60 percent) of carrier-wide prevailing charges that would otherwise go into effect with the July 1, 1984, fee screen update. In subsequent years, the Secretary would have discretion to establish the fee schedule on a regional and, ultimately, a national basis. Updates in the fee schedule should occur no more frequently than annually to refect economic and technological changes affecting the costs of producing laboratory tests.
3. Direct billing would be required as a condition for Medicare reimbursement of lab tests. That is, Medicare would no longer pay physician bills, assigned or unassigned, for laboratory tests furnished by independent laboratories. Physician bills for laboratory tests would be payable only if the physician personally performed or supervised the test. Independent laboratories would be required to bill Medicare patients or the program directly.
4. Assignment of claims need not, but could, be mandatory as a condition for Medicare reimbursement. If claim-by-claim assignment is selected, however, for assigned claims, deductible and coinsurance would not apply to laboratory charges, and program reimbursement would be made at 100 percent of the fee schedule amount (or billed charges, if lower). Unassigned claims would be subject to deductible and coinsurance requirements, and Medicare would pay up to 80 percent of the fee schedule amount. Under a mandatory assignment approach, unassigned claims for laboratory tests would not be paid. For all tests billed on an assigned basis, Medicare would pay up to 100 percent of the fee schedule. Beneficiary cost-sharing for lab charges would be waived.
5. Medicare would pay a nominal specimen collection, drawing and handling fee (e.g., $3.00) per encounter to whomever draws the specimen. This fee would be treated as a laboratory service for purposes of imposing or waiving cost-sharing obligations.
6. HCFA should simplify its information requirements for claims for clinical laboratory services to better capitalize on its role as a volume payer for health care services. Such simplification may include: elimination of the requirement that a diagnosis be shown on all laboratory bills, provided that the ordering physician is identified; minimizing the patient-specific information required on assigned bills (those paid at 100 percent); returning to the laboratory its specimen accession numbers along with the explanation of Medicare benefits; and similar changes.

The individual elements outlined above are offered as an integrated package of changes that, in combination, should work together to counter many of the problems inherent in Medicare's current reimbursement practices and should reintroduce competitive incentives to all suppliers of diagnostic laboratory services by establishing fair payment rates and methods for laboratory tests. This package represents a payment system not unlike the prospective payment system currently being implemented for most hospitals.

THE CLINICAL LABORATORY INDUSTRY AND THE MARKET FOR LABORATORY SERVICES

Background

There are more than 3,000 independent laboratories participating in the Medicare program. Their size ranges in volume from fewer than 50,000 tests to more than half a million tests performed annually, with some laboratories performing tests in only one or two specialties and others performing tests in all specialties certified by

Medicare. In addition to independent laboratories, which are defined as independent of a physician's office or a hospital, hospital laboratories and physicians' offices perform tests for ambulatory patients.

In order to qualify for Medicare reimbursement, independent laboratories must be certified by HCFA in each specialty or subspecialty in which they perform tests. Certification in turn depends on their meeting very specific personnel standards for each testing specialty, participation in a laboratory proficiency testing program, to the extent that there is one available, and the observance of specific quality control standards.

Hospitals participating in the Medicare program either must be accredited by the Joint Commission on the Accreditation of Hospitals (JCAH) or the American Osteopathic Association (AOA) or they must meet Medicare's conditions of participation for hospitals. For laboratories in hospitals not accredited by the JCAH or AOA, HCFA's requirements for quality control and proficiency testing are the same as for independent laboratories. The personnel standards are not as stringent as those in independent laboratories. HCFA has reviewed JCAH and AOA standards and determined that they are at least equivalent to HCFA's standards for hospital laboratories.

Finally, physicians who perform laboratory tests in their own offices are not subject to Federal regulation as long as they are treating only their own patients. Under Medicare regulations, physicians who accept more than 100 test referrals in any specialty or subspecialty in a calendar year are subject to HCFA's regulations for independent laboratories. In addition to Federal regulations, a few states regulate physicians' office laboratories; of these, some have only recently begun to survey physicians' laboratories.

While little data is available on physician office testing, owing in part to the absence of regulatory activity in this area, market research by manufacturers of laboratory test kits and equipment suggests that as many as 80,000 to 100,000 physicians perform some laboratory tests in their own offices. It is also widely acknowledged by such manufacturers and by independent laboratory owners and corporate officials that physician office laboratories are the most rapidly growing segment of the market supplying lab tests. Such growth appears to be consistent with technological advances that either reduce the size and cost of equipment necessary to perform tests on an automated basis or that replace complex testing methods requiring highly trained personnel with simple-to-use, inexpensive test kits.

Medicare laboratory expenditures

Total Medicare spending for non-inpatient diagnostic laboratory services under Part B is estimated to be approximately $1.6 billion in FY 1984. Of this amount, $800 million, or about 50 percent is paid to hospitals for outpatients. The remaining 50 percent, $800 million, is paid to independent laboratories and physicians. Part B spending for diagnostic laboratory services is expected to increase by between 15 and 20 percent annually over the next several years.

Of the $800 million in Part B expenditures paid on a charge basis, more than 80 percent is billed by physicians, and the balance of just under 20 percent is billed by independent laboratories directly. It should be noted, however, that while 80 percent of the non-hospital laboratory charges are included on physicians' bills, a significant share of this amount represents physicians' charges for laboratory tests performed by independent laboratories and billed to the physician, who in turn bills the patient or the Medicare program. Medicare payment record data from Rhode Island, a state that prohibits physicians from billing any patient for laboratory tests furnished by an independent laboratory, reveals that 65 percent of non-hospital lab tests in that state are billed, and thus presumably performed, by independent laboratories, with the remaining 35 percent billed by physicians.

Independent laboratories

The market for clinical laboratory services (outside the hospital) is essentially a market targeted to physicians. It is physicians, not patients, who order laboratory studies in order to arrive at a diagnosis, monitor the progress of a patient, or evaluate the efficacy of a therapeutic regimen. Hence, independent laboratories depend on physicians for their business, and they compete heavily on price, quality, timeliness of results, testing capability, availability of courier pick-up of specimens, and, occasionally, by use of rebates or other financial inducements to obtain a physician's business.

Physicians requiring laboratory tests for their patients have the option of performing these tests themselves, sending the patient to an independent laboratory or a hospital laboratory, or drawing a specimen and sending it to an independent laboratory or a hospital laboratory. In addition, where tests are referred out, the physician may opt to be billed by the independent laboratory or may request that the laboratory bill the patient or the patient's insuer. It is, is some sense, this element of choice that makes doing business with Medicare and Medicaid more costly for independent laboratories.

Specifically, when a physician test requisition indicates that the laboratory is to bill the patient or the patient's insurer, the physician does not always provide sufficient information to the laboratory to facilitate this billing option. The laboratory may have to contact the physician to secure a diagnosis, a patient's insurance policy number or Medicare identification number, date of birth, address, etc. In addition, the laboratory has to set up a billing account for that patient each time it performs services. From the laboratory perspective, it makes no sense to maintain patient-specific accounts since the laboratory may never again receive a specimen for that patient or, even if it does, the physician may request that the laboratory bill him/her in the future.

Because clinical laboratories frequently have no direct contact with patients, their collections from patients are reportedly lower than their collections from physicians. Moreover, they often have no recourse with bad debts from patients; to refuse specimens for such a patient in the future jeopardizes all of the business referred to them by that patient's physician.

In addition, the laboratories visited by the Task Force presented data demonstrating that patient collection ratios fall as the time from service to billing increases. This poses a problem with collection of Medicare coinsurance and deductibles or assigned claims, which represent more than 70 percent of independent laboratory claims to Medicare. On such claims, laboratories must wait until the Medicare carrier has processed the bill before they can attempt to bill beneficiaries for coinsurance and deductibles. The often small amounts attributable to coinsurance make beneficiary cost-sharing expensive to collect, with the result that laboratories often write these amounts off (which they are permitted to do if the cost of collection exceeds the expected return).

According to laboratory managers and trade association representatives, some physicians demand a laboratory's willingness to accept Medicare assignments or forgiveness of beneficiary cost-sharing as a quid pro quo for their business. This phenomenon may explain the relatively high assignment rate of independent laboratories; it may also account for laboratories' willingness to participate in Medicaid. In both these instances, it must be remembered that what is at stake, from the laboratory's perspective, is not merely the share of its revenues derived from Medicare and Medicaid, but all business and revenues generated by the physician-client. Physicians are reportedly reluctant to split their laboratory referral business among multiple laboratories; thus, the physician who uses one laboratory for private-pay patients is likely to use that laboratory for all patients.

To summarize the foregoing discussion, it appears that independent clinical laboratories are faced with a business environment in which:

(1) They have little or no direct contact with the patient, consequently little patient loyalty and willingness to pay promptly;

(2) Their chief responsibility is to provide high quality testing results to the physician-client; and

(3) They are financially at risk for decisions over which they have little or no control (e.g., physicians ordering unnecessary tests and having the laboratory bill Medicare on assignment, so that the laboratory may not bill the Medicare beneficiary).

Physician and hospital laboratories

The market for indendent laboratories is differential from that of either physicians or hospitals providing laboratory services to ambulatory patients. In most instances, physicians performing laboratory work in their own offices are furnishing those services to their own patients or to the patients of physicians with whom they share their practice. Because the physicians generally has ongoing contact with his/her patients, the problem with patient payments is unlikely to be as severe. Even if it is, however, physicians do have the recourse of not seeing the patient again until the patient pays his/her bill. Moreover, when physicians purchase tests from independent laboratories on behalf of their patients, they can readily deal with hard-to-collect patient accounts by requesting that the laboratory bill the patient or patient's insurer directly, reducing the physician's financial risk due to non-payment.

In the case of hospital laboratories performing work for outpatients, Medicare reimburses up to 80 percent of reasonable costs and also pays for bad debts attributable to Medicare patients. Thus, again, the problems of patient collections appear not to pose as severe a constraint for hospitals as for independent laboratories. Although the Task Force was unable to obtain quantitative data, it is commonly believed that hospitals charge considerably more than independent laboratories or physicians for laboratory tests. Historically, hospitals have argued that this practice was necessitated by Medicare cost reimbursement principles, which explicitly prohibited hospitals from employing marginal-cost pricing of outpatient services. Because marginal costs are lower that average costs, hospitals have contended that they could compete on price with non-hospital suppliers of laboratory and other outpatient services if they were not required to impose identical charges for the same services to both inpatients and outpatients.

Independent laboratories argue that both hospitals and physicians have a competitive advantage over independent laboratories because they constitute "captive" laboratories, dictating both the supply and demand for laboratory services by their patients. While the Task Force was unable to document the implications of such practices, e.g., whether they result in overrutilization of marginal laboratory tests, we believe that this area may merit further study. In the interim, however, the Task Force recommends that laboratory tests performed in independent laboratories, hospital laboratories, and physicians' offices be reimbursed uniformly. Such a policy may at least neutralize economic incentives for testing in one setting versus another and may re-introduce into physicians' offices and hospital laboratories the competitive pressures to which independent laboratories are subject.

In light of this environment, it is clear that the independent laboratory incurs costs in billing patients or their insurers that make the total package of services provided in this fashion different from the service provided and in this fashion different from the the service provided and billed to physicians. This distinction, considered by some to be analogous to the difference between wholesale and retail marketing, is used by the laboratory industry to justify their differential pricing patterns. Regardless of the degree to which such price differences can be justified in the absence of quantitative data on costs of servcing patients versus physicians, the Task Force began to turn its attention away from the magnitude of the pricing differential or its reasonableness and began to focus instead on the questions of how HCFA claims processing and payment rules could be modified so that HCFA could act as a more prudent purchaser of laboratory services and thereby warrant establishing Medicare reasonable charges at levels comparable to laboratory prices to physicians.

LABORATORY REIMBURSEMENT UNDER MEDICARE

Background

Diagnostic laboratory services billed by physicians and dependent laboratories are paid on the basis of customary, prevailing and reasonable charges, similar to all other Part B services billed on a charge basis. Laboratory services performed by hospitals for their outpatients are paid on the basic of reasonable costs. Hospitals acting as independent laboratories, that is, accepting patient specimens from physicians in the community, are treated like independent laboratories: they may bill the physician upon his request, and the physician may in turn bill the beneficiary or the program; or they may bill the patient or the Part B carrier directly. In either situation, reimbursement is limited by the prevailing charge in the locality for the tests performed. In addition to the comparison of actual charges, customary charges, and prevailing charges, a number of other criteria are used to limit the amount that may be considered the reasonable charge for Medicare Part B payment purposes. These criteria, and their basis in statute and regulations, are described below.

Lowest charge levels

Three major legislative changes have attempted to address the problem of establishing appropriate payment limits for Medicare reimbursement for diagnostic laboratory tests. The Social Security Amendments of 1972 included two such changes. The first of these, section 224(b), amended section 1842(b) of the Social Security Act to provide that:

"In the case of medical services, supplies, and equipment (including equipment servicing) that, in the judgment of the Secretary, do not generally vary significantly in quality from one supplier to another, the charges incurred after December 31, 1972, determined to be reasonable may not exceed the lowest charge levels at which such services, supplies, and equipment are widely and consistently available in a locality except to the extent and under the circumstances specified by the Secretary."

The accompanying Senate Finance Committee Report suggests that the Congress anticipated that this authority would permit the establishment of fee schedules for broad geographic or medical service areas served by carriers. Instead of defining laboratory prices to physicians as the "lowest charge levels" at which laboratory services were "widely and consistently available", the regulation implementing this provision in July 1978 established payment limits at the 25th percentile of actual charges, with a provision for using more recent charge data than that used to set prevailing charges (i.e., 3-6 month old charge data rather than 12-18 month old charge data). The regulation also provided for updating the lowest charge levels twice a year, in January and July. The regulation was accompanied by a notice that the lowest charge regulation would apply initially to 12 common lab tests and two items of durable medical equipment. This list has never been updated for Medicare; a few additional tests were included for Medicaid.

Negotiated payment rates

The second provision of the 1972 Amendments authorized the establishment of negotiated payment rates for diagnostic lab services, with waiver of beneficiary coinsurance amounts for those services billed by independent laboratories on an assigned basis. This amendment stemmed from the belief that laboratories increased their charges to the Medicare program relative to their physician prices in order to assure that Medicare reimbursement at 80 percent of charges was sufficiently high to cover their costs and allow them to forgive coinsurance. While Congress recognized that beneficiary coinsurance on lab claims was often too small to warrant collection efforts by independent laboratories, the statute did not permit waiver of beneficiary deductible amounts applied to laboratory charges. As a result of this omission, this provision has never been implemented because independent laboratories have been unwilling to negotiate reduced reimbursement rates for Medicare, knowing that they would still have to attempt to collect unmet deductible amounts from patients.

Prohibition on physician markups

The third legislative change to Medicare reimbursement for clinical laboratory tests attempted to address the problem of physician mark-ups of charges made to them by independent laboratories on behalf of their patients. Section 918 of the Reconciliation Act of 1980 limited Medicare program reimbursement to physicians billing for tests furnished by independent laboratories to 80 percent of the lowest of the physician's billed charge, the independent laboratory's customary charge, or the independent laboratory's charge to the physician. Where the physician indicated that the test was furnished by an independent laboratory but failed to identify both the laboratory and the laboratory's charge to him or her, carriers were instructed to estimate the lowest charge at which a physician in that locality could secure a test from a Medicare participating laboratory serving the locality. These limits did not apply to charges made by physicians for laboratory tests they personally performed or supervised.

Regulations implementing this provision became effective April 1, 1981. This amendment represents the first Congressional effort to eliminate opportunities for physicians to mark up discounted laboratory prices. It should be noted, however, that the statutory change does not preclude physicians from continuing to mark up such charges and simply passing on these charges to beneficiaries on unassigned claims. Neither the statute nor the regulation prohibits Medicare payment for lab tests where the physician charges the beneficiary more than he/she was charged by an independent laboratory or where there is insufficient information to determine that the test was in fact purchased from an independent laboratory. In fact, if the physician indicates on his/her bill that the independent laboratory charge was $5.00 and his/her charge is $15.00, it is the $15.00 that will be entered into Medicare carrier files for purposes of profiling charge patterns and establishing the subsequent fee screen year's prevailing charge for that service. Assuming that it is lower than the independent laboratory's customary charge, the $5.00 will be the Medicare allowable charge, and Medicare reimbursement at 80 percent will be $4.00. Hence, on an assigned bill, the beneficiary will be liable for $1.00 in coinsurance; but on an unassigned bill, the beneficiary will be liable for $1.00 in coinsurance and the full $10.00 difference between the reasonable charge and the physician's actual charge.

Recognizing that the effect of such provision might be to increase beneficiaries' out-of-pocket costs, Congress mandated a study of the effects of section 918 on physician billings for lab tests and resultant Medicare payment reductions. HCFA's report to the Congress, submitted on May 19, 1983, indicated that a very small percentage of bills failed to indicate who performed the laboratory tests billed by physicians. However, this result must be viewed cautiously, since the payment limits of section 918 do not apply to work performed in a physician's office. The Inspector General, in a recent review of laboratory reimbursement under Medicare, notes that claims data reveals a substantial increase in the percentage of tests for which the place of service is identified as the physician's office. It is not clear what this finding reflects. It could reflect a real change in practice patterns, with physicians performing more of their own tests, in order to circumvent payment limits that would otherwise apply, or it could reflect fraudulent reporting of place of service data by physicians. Alternatively, if payment limits have reduced physician assignment rates for laboratory services, it could reflect beneficiaries' lack of awareness that lab work billed by their physicians was performed outside their physicians' offices. Historically, carriers reviewing physician bills for laboratory services have assumed the place of service to be the physician's office where no place of service was specified. Even if carriers are now attempting to document the place of service on lab bills from physicians, they may be getting inaccurate informatiom from beneficiaries who do not know that the lab specimen taken by their physician was sent to an outside laboratory.

HCFA's report to Congress otherwise found that section 918 resulted in reduced payments in a similarly small percentage of physician bills or requests for payment. On such bills submitted by the physician (presumably assigned bills), the reduction averaged 4.5 cents per test. On bills submitted by the beneficiary (presumably unassigned), the reduction averaged 14.5 cents per test. These figures are considerably smaller than the price differentials found between independent laboratories' charges to Medicare and their discounted prices to physicians for the same service. Consequently, either significant price differences do not exist or section 918 is having limited effect in reducing Medicare recognition of physician markups of laboratory prices. According to some laboratory operators, who do acknowledge maintaining differential prices for account billings (to physicians) and individual patients or insurers, some physicians have attempted to circumvent section 918 payment limits by requesting that independent laboratories bill them the full "retail" price for Medicare and Medicaid patients. In exchange for higher reimbursement for federally insured patients, such physicians have requested deeper discounts on their non-federal lab referrals, where they can pass along marked up charges to patients and their insurers without limit.

Administrative changes

In addition to the legislative changes that have added lowest charge levels and laboratory prices to physicians to the comparison of actual, customary, and prevailing charges in the determination of Medicare's reasonable charge, a number of administrative changes are worthy of note. The first of these is that, since March 1978, carriers have been advised that "a diagnostic laboratory test, whether performed in a physician's office, in an independent laboratory, or in another laboratory, is to be treated by the carrier as a laboratory service. . . . Also, when physicians and approved laboratories perform the same test, . . . the services will be deemed similar and the respective customary charges of all physicians and approved laboratories for that test should be commingled in the computation of the prevailing charge in the locality for the test." (Medicare Carriers Manual, Section 5114, March 1978). This means that for payment purposes, Medicare does not recognize specialty differences but maintains a single prevailing charge for lab tests, reflecting the distribution of all charges by all suppliers billing for such tests.

This same instruction sets forth rules for determining when a separate specimen drawing or collection and handling charge could be paid to physicians, and limits the reasonable charge for such specimen handling fees to $3.00.

The collapsing of specialty-specific prevailings into a single prevailing charge for laboratory tests was further clarified in September 1978 by a carrier manual amendment specifying that laboratory tests, even when performed by a physician, are not subject to the Medicare economic index limiting prevailing charges for physicians' professional services.

Also in 1978, as a result of concern over physician mark-ups of independent laboratory charges, a Laboratory-to-Physician Charge Screen (LPS) was added to the carrier determination of the reasonable charge. This screen, which went into effect in 1979, was intended to "relate the reasonable charge for a laboratory service that is billed for by a physician (who did not perform the diagnostic test) to the charges that physicians in the carrier's jurisdiction are paying to independent laboratories generally for similar services." The LPS was to be set at the 75th percentile of charges made to physicians by laboratories servicing the carrier's entire service area. Calculation of the LPS was to be based on the most current laboratory price lists (for services to physicians) that could be obtained to permit timely update of reasonable charge screens in July of each year. This change was superceded by section 918 and, as such, has not been consistently maintained and updated by the carriers. A number of regional offices, however, in their review of this Task Force's draft report, suggested that the published price list data used by carriers to establish the LPS was more readily available and more reliable a means of establishing laboratory test reimbursement rates than data reported by physicians consequent to section 918.

RECENT CRITICISMS OF CURRENT MEDICARE REIMBURSEMENT PRACTICES

Background

Criticisms of Medicare's laboratory reimbursement policy have been levied over the past several years by the General Accounting Office (GAO)[2], the Office of the Inspector General (OIG)[3], and the Oversight and Investigations Subcommittee of the House Energy aand Commerce Committee.[4] While the specific problems cited and remedies proposed by these parties have tended to differ slightly, the common thread running through all of this criticism has been that the Medicare program is not a prudent purchaser of diagnostic laboratory services, and it has long been a victim of price discrimination by independent laboratories and of unwarranted price mark-ups by physicians, and that its recognition of these "excessive" fees has resulted in inappropriate payment levels.

Many of the legislative and administrative activities documented in the previous section of this report were designed to better enable the Medicare program to capture the benefit of the lowest price available to all purchasers of laboratory tests (i.e., the discounted, wholesale, or volume-based price that characterizes transactions between independent laboratories and physicians). Each of these changes, however, was only an incremental step toward one piece of the market supplying laboratory tests. Taken together, they represent a rather piecemeal approach to rationalizing Medicare reimbursement for diagnostic laboratory services.

Moreover, each change made to fix one part of the problem either has led to other problems or has altered the economic incentives and pricing behavior of physicians or independent laboratories. The end result is a Medicare reimbursement policy in which payment levels for the same service very with who submits the bill and how much detail the billing entity provides about the place of service and the supplier's charge. For example, three identical tests performed by a single independent laboratory could be paid at different levels if: in one case, the laboratory bills the physician and the physician identifies the laboratory *and* its price on his/her bill; in another case, the laboratory bills the physician, whose bill does not include the name of the laboratory or its charge; and, in the third case, the laboratory bills the program or the patient directly. Such a policy becomes even more complex to understand and to administer when the physician is serviced by one carrier and the laboratory, because it is located in a different state, is serviced by another.

Although such patterns are difficult to discern when using aggregate data, the Task Force sought to identify trends in test ordering and billing in order to estimate the magnitude of the problems. It also attempted to assess the incentives underlying such trends so as to identify the likely impacts of current procedures and proposed reforms. The following discussion lays out our findings with respect to the criticisms of Medicare laboratory reimbursement.

Price discrimination

The Task Force rejects the Inspector General's and the Oversight and Investigations Subcommittee's designation of the two-tiered pricing structure maintained by independent laboratories as discriminatory. No evidence has been presented to indicate that laboratories charge Medicare and Medicaid patients more than they charge any other individual patients or insurers for laboratory services. Rather, the entire basis of the price discrimination argument lies in the fact that inependent laboratories routinely bill physicians for the same test less than they bill individual patients—including Medicare, Medicaid, Blue Cross/Blue Shield, commercially insured, and private pay patients.

It should also be noted that, while much attention has been devoted to charge differentials, there is little documentation to demonstrate that Medicare's actual payments to laboratories are greater than physician payments for the same service.

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[2] Comptroller General of the United States, "Tighter Controls Needed Over Payments For Laboratory Services Under Medicare And Medicaid" (HRD-76-121), August 4, 1976, and "Savings Available By Contracting For Medicaid Supplies and Laboratory Services" (HRD-78-60), July 6, 1978.

[3] Office of the Inspector General, Department of Health and Human Services, "Despite Years of Attention: Clinical Laboratory Tests Still Cost Medicaid/Medicare Too Much," March 8, 1982.

[4] "Kickbacks In Clinical Laboratories," Hearing before the Subcommittee on Oversight and Investigations of the Committee on Energy and Commerce, House of Representatives, March 5, 1982.

Such is the implication of discussions comparing Medicare's prevailing charges and laboratory-to-physician price lists. The Task Force believes, however, that such comparisons are inconclusive at best. While the OIG and the Oversight and Investigations Subcommittee have cited numerous instances where Medicare prevailing charges exceed laboratory prices to physicians, they have not substantiated their conclusion that Medicare is actually paying directly-billed independent laboratory services at the prevailing charge. In fact, most program data suggest the reverse: that laboratories billing directly are paid at less than the prevailing charge and that physicians' charges for laboratory services account for both the bulk of laboratory bills (more than 80 percent of charge-reimbursed laboratory bills) and the level of the Medicare prevailing charge.

The Task Force does acknowledge that independent laboratories may face incentives to raise their charges to individuals for laboratory tests both to assure that Medicare reimbursement at 80 percent of the reasonable charge is sufficient to cover their costs and to increase their customary charges for carrier profiles. Concern with fee profiles is probably common to all physicians and suppliers paid on a reasonable charge basis; however, the objective of covering costs through Medicare payments alone (i.e., without beneficiaries' share of reasonable charges) may play a greater role in laboratory pricing policy than in other services and supplies, especially given the difficulty laboratories claim to have in collecting patient cost-sharing liability.

Physician charges for laboratory tests

A second inference follows from aggregate program data on the distribution of laboratory charges between physicians and independent laboratories. If the prevailing charge for a given test is considerably higher than laboratories' prices to physicians, this reflects either significant physician in-office testing and higher prices for laboratory tests or it suggests that physicians purchasing tests from independent laboratories are marking up their charges to Medicare beneficiaries or the program. The latter interpretation is consistent with data presented in HCFA's report to Congress on the impacts of the Reconciliation Act of 1980 provision limiting payment to physicians for tests furnished by independent laboratories.

As a result of examining such data, most members of the Task Force were concerned that neither the program nor its beneficiaries are adequately protected from physician fees in excess of the competitively set prices characteristic of the laboratory-to-physician market. Because physicians bill for more than 80 percent of the nonhospital laboratory services to Medicare beneficiaries, and because physicians have considerably lower assignment rates for lab services than do independent laboratories (44 percent for physicians compared to more than 70 percent for laboratories), the Task Force believes that the question of establishing appropriate payments to physicians performing or billing for lab tests has been neglected.

Medicaid payment rates

Additional criticism relating to the level of payment for diagnostic lab tests compares Medicare unfavorably with Medicaid and notes the success some states have had in reducing laboratory test fees by as much as 40 percent across the board without reducing laboratory participation in Medicaid. The Task Force is again concerned with the lack of understanding of the market for laboratory services evidenced by such observations. It must be remembered that independent laboratories are competing for essentially all of a physician's testing referrals, not just Medicare patients, Medicaid patients or privately-insured individuals. Thus, to refuse to accept referrals for a physician's Medicaid patients potentially jeopardizes a lab's entire account with that physician. In addition, because of the mandatory assignment requirements under Medicaid, a laboratory has no choice but to accept Medicaid payments as payment in full, regardless of what the laboratory charges Medicaid. In fact, the Task Force raised the question of whether inadequate reimbursement levels under Medicaid might be generating higher charges to Medicare, private insurers, and physicians in order to recover losses stemming from Medicaid business.

ALTERNATIVES CONSIDERED BY THE TASK FORCE

Objectives

The Task Force evaluated a number of alternative approaches to reduce the rate of program cost increases for diagnostic laboratory services. These alternatives derived from our attempt to address several criticisms of Medicare laboratory reimbursement policy and were evaluated in terms of the following objectives:

1. Establishing payment rates and procedures that would permit HCFA and its beneficiaries to benefit from Medicare's role as a volume payer of diagnostic laboratory services;
2. Eliminating opportunities for physician mark-ups of laboratory charges, thereby reducing the economic incentives for physicians to order unnecessary laboratory studies; and
3. Reducing the administrative burden of Medicare participating laboratories in dealing with the program or its beneficiaries;
4. Maintaining the competitive structure of the clinical laboratory industry without subsidizing inefficiencies within segments of the market.

In addition, the Task Force did not seriously consider attempting to secure detailed data from the various segments of the diagnostic testing market in order to estimate the costs to differing entities of performing tests and the costs of other activities, such as securing patient specimens, marketing, and billing, which might be expected to vary with supplier type. Instead, the Task Force worked from the assumptions that (1) the discounted prices of transactions between physicians and independent laboratories reasonably approximate the efficient price of laboratory services in a competitive marketplace, and (2) independent laboratories would make such prices available to Medicare if dealing with the program were more like dealing with a physician. Consequently, we sought to identify ways in which current Medicare reimbursement practices could be changed ot allow Medicare to more closely resemble the physician-purchaser of laboratory tests.

Incremental changes

Because the Task Force had identified a number of ways in which the current reimbursement methodology either failed to promote the objectives outlined above or established perverse incentives for physicians, hospital and independent laboratories, our consideration of incremental changes to the current system was quite limited. Extending the lowest charge levels to a broader range of laboratory tests and including laboratory prices to physicians in carrier profiles for establishing prevailing charges represented two such incremental approaches.

While the application of the lowest charge levels might reduce program expenditures, its impact on beneficiary out-of-pocket liability depends on whether or not reduced Medicare payments simply translate into reduced assignment rates for laboratory tests. The potential for this outcome is especially great if physicians continue to bill for the bulk of laboratory services. Further, application of the lowest charge levels might also generate more rapid increases in laboratory and physician charges for affected tests, since the lowest charge levels are updated twice annually with more current charge data than prevailing charges. By the same token, the use of laboratory-to-physician prices in the calculation of prevailing charges could have similar effects. Moreover, while laboratories might be willing to provide carriers with such information in the form of published price lists, the failure of physicians to report when tests are purchased from independent laboratories complicates the issue of weighting such prices for the frequency of tests purchased from various laboratories.

Waiver of beneficiary cost-sharing

One of the predominant ways in which dealing with Medicare is different from dealing with physicians is that Medicare pays only 80 percent of the reasonable charge for services after the Part B deductible has been met. Physicians, on the other hand, are liable for 100 percent of the amounts billed them by independent laboratories. Moreover, because the reasonable charge is the lowest of the actual, the customary or the prevailing charge for a service, a laboratory billing Medicare at its physician price would be paid only 80 percent of that price (if the deductible has been met) and would have to render a second bill to the beneficiary for the balance of 20 percent. This is the case even if the actual charge is considerably below the prevailing charge level, simply because Medicare does not reimburse 100 percent of expenses under Part B. Thus, laboratories currently have no incentive to reduce their prices to Medicare in order to eliminate the need to bill the beneficiary. Reduced prices to the program simply translate into reduced reimbursement amounts.

What independent laboratories want is 100 percent of the prices they bill physicians. The Task Force reasoned that if lab-to-physician prices are 25 percent or more below the customary laboratory-to-patient price or prevailing charge, it would be no more costly to the Medicare program to pay 100 percent of lab-to-physician prices than to pay 80 percent of reasonable charges. However, because part of the laboratory industry's basis for two-tiered pricing is the high costs of beneficiary collections, the Task Force believes that waiver of coinsurance and deductible requirements should be limited to those instances in which the laboratory agrees to accept assignment and not bill any additional amount to the beneficiary.

Thus, waiver of coinsurance and deductible requirements on laboratory charges on assigned independent laboratory claims represents the first recommendation adopted by the Task Force. This step would enhance beneficiary protection against out-of-pocket costs for direct-billed independent laboratory services and is also consistent with the Administration's FY 1984 legislative proposal to waive the deductible for laboratories with which the Secretary had negotiated payment rates (see pp. 8–9). Absent any other changes, however, this effect would be limited to the 18–20 percent of tests billed directly by independent laboratories and would depend on the continued willingness of laboratories to accept assignment at their relatively high current rate.

The willingness of laboratories to accept Medicare assignment is likely to be sensitive both to the Medicare payment level and to the competitive pressure exerted by physicians requesting that laboratories accept assignment in exchange for their business. On the other hand, the volume of tests billed directly to the program by independent laboratories is a function of the total volume of Medicare business they perform and of the billing options available to physicians under current reimbursement policy. The latter is a policy variable that HCFA could seek to modify.

Direct billing

Direct billing means that the party performing a laboratory test is the only entity that could be reimbursed for it by Medicare. Hence, physicians' bills for laboratory services would be payable only if the physician personally performed or supervised the test in his own office. Independent laboratories participating in the Medicare program would be required to bill patients or the program directly for all tests, and could no longer bill physicians who in turn bill the beneficiary or the carrier. This approach would more effectively eliminate physician opportunities to mark up laboratory charges than the Reconciliation provision limiting Medicare payments to physicians billing for outside lab work.

The major disadvantage of direct billing is that it will increase the number of Part B bills, but carriers with whom the Task Force met noted that independent laboratory bills are among the least expensive to process and independent laboratories have availed themselves of electronic media billing more than most other suppliers. There was also concern that direct billing might encourage additional testing in physicians' offices or that physicians unable to profit from mark-ups on independent laboratory tests would refuse to accept Medicare assignment for non-laboratory services in order to make up for lost income. Another disadvantage of direct billing would occur if a decision were made to reimburse only the attending physician for a beneficiary's illness under a prospective payment type system.

The Task Force viewed the question of whether reimbursement policy should encourage or discourage additional physician office testing as beyond the scope of our charge and intrinsically tied to medical judgments. While some studies suggest that laboratory testing quality is poorer in physicians' offices than in independent or hospital laboratories, most of this evidence is old and pre-dates new and better test kits or the use of automated equipment by physicians. Our more general concern was that HCFA be able to establish fair prices for laboratory services and not unduly reward physicians relative to other suppliers of lab tests, since physicians control overall laboratory utilization.

Research on physician reimbursement, on the other hand, strongly suggests that physicians decide whether or not to accept Medicare assignment on the basis of Medicare reimbursement levels for medical services rather than on Medicare payment levels for ancillary services such as X-rays and laboratory tests.[5] Hence, we were less concerned that precluding Medicare payment to physicians for purchased laboratory tests would reduce assignment rates for physician services as a whole.

Weighing in favor of direct billing are quality and utilization arguments. By eliminating the potential for physicians to mark up the estimated 40–50 percent of laboratory tests produced by independent laboratories but billed by physicians, direct billing could likewise reduce financial incentives for over-testing. Moreover, since physicians are not required to name the laboratory from which they purchase tests, direct billing would help assure that Medicare is paying for tests only from Medicare-certified laboratories or those furnished directly by physicians.

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[5] Thomas H. Rice, "Determinants of Physician Assignment Rates: An Analysis by Type of Service," (Menlo Park, California: SRI International, Health Policy Research Series), October 1982.

The final argument for direct billing lies in the fact that, even under current reimbursement provisions, independent laboratories have an assignment rate in excess of 70 percent. Thus, assuming that independent laboratories perform some 60–70 percent of non-hospital Part B laboratory services and would continue to accept assignment as frequently as under current law, the financial protection afforded Medicare beneficiaries by requiring direct billing would increase. Moreover, savings would also accrue to the Medicare program to the extent that payments to independent laboratories are lower than payments to physicians for laboratory tests. Part B bill data comparing independent laboratories to internists, the physician specialty accounting for the largest share of laboratory billings, shows lower average submitted charges, approved charges, and rates of increase from 1976 and 1980 for independent laboratories, while the assignment rate of internists is about half that of laboratories.

As the table on the following page indicates, independent laboratory charges to the program grew at a lower rate during the 1976–1980 period than the laboratory charges of all other specialties billing for laboratory tests under Part B. This was true of both actual charges and of approved (reasonable) charges, on which program payments are based. Hence, the Task Force concluded from its evaluation of these data and the foregoing discussion that the advantages of direct billing, to both the Medicare program and to its beneficiaries, outweigh the disadvantages. On that basis, the Task Force decided to incorporate direct billing as a second recommendation for reforming Medicare reimbursement for diagnostic laboratory services.

Physician office laboratories

As noted above, the discussion of direct billing had also raised questions about the potential for reimbursement policy to influence physicians' decisions both to perform tests at all and whether to perform such tests in their own offices or to refer them out. The Task Force thus arrived at the conclusion from its discussions of physician office testing that program reimbursement should be neutral with respect to where testing takes place. As such, the Task Force recommends that Medicare pay no more to physicians performing their own tests and thereby billing the program or patient directly than it pays for tests performed and billed by independent laboratories.

The decision to treat physicians and independent laboratories indentically raised the broader issue of whether we should strive for uniformity of reimbursement policy for all Part B laboratory services to ambulatory patients. Should proposed reimbursement changes apply equally to physicians and to hospital laboratories performing tests for their own outpatients and for private referrals? More specifically:

1. Should the waiver of coinsurance and deductible amounts, thus 100 percent program reimbursement, apply to tests performed by physicians and hospital laboratories for outpatients, as well as to tests performed by independent laboratories?
2. Should specimen collection and handling fees be paid to independent laboratories and outpatient laboratories drawing specimens as well as to physicians drawing specimens for outside referral work?

Essentially, the Task Force said yes to all of these questions. By this time in our deliberations, we had come to view an alternative reimbursement system as similar to prospective payment for hospitals in that we believed Medicare reimbursement for basically the same laboratory services should be the same regardless of who provides the tests. Such an approach maintains reasonably competitive market incentives without being unnecessarily intrusive with respect to medical decisions to order tests and where to have them performed. It could reasonably be argued that physicians sometimes perform tests in their own offices because they want the results while the patient is still present. By the same token, when referring tests to independent or hospital laboratories, physicians make decisions as to what outside laboratory to use on the basis of such factors as price, laboratory willingness to accept assignment, and their perception of laboratory quality and timeliness of results.

MEDICARE PART B—DIAGNOSTIC LABORATORY CHARGES AND SPECIALTY ASSIGNMENT RATES

Specialty	Average Medicare approved charge per service		Average annual compound growth rate (percent) 1976–80	Average submitted charge per service		Average annual compound growth rate (percent) 1976–80	Specialty assignment rate for lab charges (percent)		Seecialty share of total Medicare part B laboratory reimbursement (percent)	
	1976	1980		1976	1980		1976	1980	1976	1980
Internal medicine	$7.51	$10.19	7.9	$8.85	$13.00	10.1	38	34	32.2	26.8
Independent labs	6.95	8.87	6.3	8.03	10.86	7.8	72	73	18.5	18.6
General practice	5.78	7.49	6.7	6.90	9.88	9.4	44	38	14.8	8.6
Clinic	8.39	10.99	7.0	9.89	13.82	8.7	46	37	6.8	7.4
Cardiovascular	11.98	21.19	15.3	14.09	26.32	16.9	52	52	4.4	7.0
Family practice	6.29	8.06	6.4	7.45	10.52	9.0	50	40	3.1	5.0
All others	5.97	9.66	12.8	7.22	12.12	13.8	59	57	20.2	26.6

Source: HCFA Bureau of Data Management and Strategy; HCFA Office of Legislation and Policy.

Hospital laboratories

The argument for applying the same reimbursement rules to hospital laboratories was somewhat different. Since passage of the Omnibus Budget and Reconciliation Act of 1981, the Department has had authority (under Sec. 1861(v)(1)(K)) to impose limits on the reasonable costs of services in hospital outpatient departments. This authority excludes bona fide emergency services in emergency rooms and requires that cost limits be reasonably related to charges for similar services in physicians' offices in the locality. HCFA has not developed such cost limits for a number of reasons, including differences in the way services are identified and billed by physicians versus outpatient departments and the lack of case-mix data comparing hospital outpatients and patients seen in physicians' offices.

In the area of laboratory tests, however, the services are essentially identical; that is, with the occasional exception needed on an emergency basis, a complete blood count is the same service regardless of how sick the patient is or where the test is performed. Hence, it is not an impossible task to relate a cost limit for laboratory services to the charges for laboratory services furnished outside the hospital.

Moreover, hospitals maintain laboratories primarily for the care of their inpatients. As noted earlier (see p. 6), hospitals have long maintained that they should be able to use marginal cost pricing for services rendered to outpatients because this would result in a more accurate allocation of costs between their inpatient and outpatient services. In addition, prospective payment limits for inpatient hospital services are likely to give hospitals incentives to move services to the outpatient setting wherever feasible. One probable area is diagnostic testing that could be provided before a patient is admitted for inpatient care. While the shift to outpatient settings may be medically appropriate and, in the long run, desirable on policy and fiscal grounds as well, we believe that hospitals should not be immune to the competitive forces facing other suppliers of laboratory tests by a blanket exemption for hospital laboratory services to non-inpatients. Thus, the Task Force recommends that hospitals be paid no more than other parties for laboratory services rendered to ambulatory patients. We do believe, however, that the Secretary should have authority to provide for exceptions or adjustments for laboratory tests provided as part of a bona fide emergency service in the emergency room (as defend in HCFA regulations).

The reasons for waiving beneficiary cost-sharing obligations were less compelling for physicians and hospital outpatient departments, which would still have to render a bill to beneficiaries for coinsurance and deductible amounts applied to non-laboratory services. Having moved this far toward uniformity of Medicare Part B laboratory reimbursement policy, the Task Force saw no reason to limit waiver of coinsurance and deductible requirements to assigned claims only from independent laboratories. In addition, it is hoped that 100 percent reimbursement for laboratory tests or assigned claims might induce some physicians to accept assignment for tests performed in their own offices.

The objective of uniformity also informed the Task Force's recommendation that Medicare pay a specimen collection and handling fee, limited to one per encounter, to whatever party—indepedent laboratory, hospital, or physician—draws the patient specimen. Currently, nominal specimen collection fees are generally paid only to physicians drawing specimens and having the tests performed by indendent laboratories. In an effort to establish fair payments for services performed, it seems incumbent on the program to recognize the costs of these services by whomever draws the specimen.

Assignment options

Since hospitals are required under current law to accept assignment for all outpatient services rendered to Medicare beneficiaries, and since independent laboratories already have a relatively high assignment rate, the Task Force turned its attention to the general issue of assignment options. Specifically, we attempted to evaluate the appropriateness of mandating assignment for all laboratory services as a condition of Medicare reimbursement. The primary reasons for mandating assignment were to enhance beneficiaries' financial protection and to subject physicians to the same economic constraints operating on independent and hospital laboratories. If physicians are not required to accept assignment, they would continue to be able to pass on higher charges to beneficiaries than the program would recognize. In light of the inability of Medicare to require physician participation, however, some members of the Task Force were convinced that requiring laboratory bills to be assigned would simply result in non-payment of diagnostic laboratory bills from physicians who refuse to accept assignment and thus reduce overall beneficiary protection. In addition, some members of the Task Force felt that physician assignment options for laboratory services should be resolved in the broader context of physician reimbursement reform and possible changes in the context of Medicare participation. Absent any means of affirmatively requiring physicians to participate in the Medicare program, at least with respect to laboratory tests, the Task Force is divided on the merits of limiting reimbursement to assigned claims only. The Task Force's sole recommendation with respect to assignment options is that HCFA policy be uniform for both physicians and independent laboratories.

Reimbursement levels

The final and most difficult problem remaining was the overall framework or system by which to establish the Medicare reimbursement level for diagnostic laboratory services. The Task Force had, as noted early on, determined that laboratory prices to physicians were probably the best price available in the existing marketplace for diagnostic testing services. Comparisons of such data to current Medicare reimbursement levels are limted to small samples, however, and carriers vary widely in how much information they have on laboratory prices to physicians. Thus, the Task Force considered three principle options for establishing payment rates, described briefly below.

The first option was a competitive bidding system, whereby the Medicare program could enter into contracts with qualified laboratories offering the lowest prices and limit program payments to those laboratories, thus waiving beneficiaries' freedom of choice as to which laboratories could perform Medicare-covered services. This approach was consistent with the flexible authority sought as part of the Administration's FY 1984 legislative proposal to permit negotiated rates or volume purchasing arrangements.

A variation on the competitive bidding system described above was to use the bidding process to establish payment rates in geographic areas, pay 100 percent of the competitively-bid prices to the "winning" laboratories, but permit Medicare payment at 80 percent of the bid prices to all other laboratories participating in the program.

The second option considered was the use of negotiated payment arrangements with independent laboratories. Under such agreements Medicare could waive laboratory coinsurance and deductibles if negotiated rates were sufficiently low to assure that program payments would not exceed what they would have been in the absence of the provision. This approach was also consistent with the FY 1984 proposal to waive deductible amounts (waiver of coinsurance is permitted under current law) for laboratories having negotiated rate agreements with the Secretary.

The third alternative evaluated by the Task Force was the adoption of fee schedules for laboratory tests. The fee schedule amount would be derived from claims data identifying laboratory prices to physicians, if this proved feasible, or from current program data on customary and prevailing charges, reduced by a fixed percentage. Medicare would not limit the number of laboratories participating in the program, but would reimburse all qualified suppliers of laboratory services on the basis of the fee schedule, at 100 percent if the claim were assigned and 80 percent if unassigned.

Competitive Bidding.—While the underlying basis for competitive bidding was to enable Medicare to obtain the lowest available price by assuring laboratories substantial volume, the Task Force had a number of reservations about wide-scale implementation of this option. First and foremost was the disruptive effect that limiting the number of Medicare-participating laboratories could impose on the industry as a whole. Since laboratories compete for all of a physician's business and not just his Medicare business, and since physicians reportedly do not split their testing among multiple laboratories, limiting the number of laboratories eligible for Medicare reimbursement could likewise limit the overall number of laboratories physicians use for their private business as well. In effect, competitive bidding might create local monopolies in some areas of the country. While Medicare might benefit from heavily discounted prices in the short run, the possibility that "winning bidder" laboratories might drive out their competition could result in higher costs to Medicare in the long run as fewer laboratories remained in business.

In addition to possibly subjecting the Medicare program to monopoly power in the future, the designation of winning laboratories on the basis of oprice alone raised questions about the effects of competitive bidding on quality of services. Laboratories might knowingly underprice the competition in order to win a Medicare contract, even if they know they will be unable to cover their costs at the bid price. This practice, known as "low-balling," has occurred in even limited competitive contracts for laboratory services awarded by the Air Force and by the District of Columbia. When winning laboratories have been unable to deliver service, there was no other laboratory willing to act as a back-up at the budgeted price. Even when performance is not so poor as to merit termination of a contract, physicians dissatisfied with the service of a winning laboratory or the quality of its results may use non-participating laboratories and thus leave the beneficiary totally at risk for the cost of lab tests.

The variation under which the bidding process is used to establish the price and to designate laboratories eligible for 100 percent reimbursement versus 80 percent payment to all other laboratories was viewed as less disruptive to the industry and to overall testing quality, since freedom of choice would be maintained. However, the incentive to bid is probably diminished since the Medicare program would be unable to guarantee a minimum volume to those laboratories offering the lowest price. Moreover, assuming the terms of competitive bidding would require acceptance of Medicare's payment as the full price for lab tests, "winning" laboratories could conceivably be worse off than non-winning laboratories, which would be free to bill beneficiaries at whatever price they choose.

Finally, under both competitive bid options, the Task Force identified a number of operational and administrative issues that would have to be resolved. Among these were the determination of who would operate the bidding system, carriers, regional offices, HCFA's central office, or an agent expressly contracted with to carry this activity out. The need to project volume of Medicare demand, the development of a consistent methodology for evaluating bids, the need to provide for back-up arrangements in the event of non-performance by a winning laboratory, decisions with respect to whether physicians and hospital laboratories could bid, and other similar issues suggested that the implementation of a bidding system could be administratively cumbersome and quite costly. A number of these issues are being addressed by the Center for Health Policy Studies of Columbia, Maryland, under HCFA Office of Research and Demonstrations contract to design a competitive bidding system for laboratory services. As such, the Task Force concluded that it was premature to implement a competitive bidding system without a demonstration of its viability.

Negotiated Payment Rates.—Similar operational concerns characterized the Task Force's evaluation of negotiated payment rates to establish Medicare reimbursement levels. Laboratory-by-laboratory negotiations could be time consuming and complicated. The willingness of laboratories to reduce prices without gaining a competitive advantage vis-a-vis other laboratories is also quetionable. Moreover, prices tailored to individual laboratories runs counter to the objective of making Medicare reimbursement uniform regardless of who furnishes the services. Therefore, the Task Forces rejected negotiations as the means of establishing Medicare payment rates for laboratory tests.

Fee Schedules.—The discussion of fee schedules arose both out of the Task Force's inability to resolve the implementation issues related to competitive bidding or negotiated payment rate approaches and because one of the underlying objectives of the Task Force was to establish payment methods that allow the savings associated with laboratory-to-physican prices to accure to the benefit of the Medicare program and its beneficiaries. Because program data and information from regional offices suggested that physicians were not reporting significant laboratory price discounts on Medicare claims, the Task Force sought an alternative approach to establishing fee schedules. Most readily available were the customary and prevailing charge profiles already maintained by carriers for Part B reimbursement.

Fee schedules could be created relatively easily by using charge distribution data and setting the maximum fee schedule amount either by taking a percentage of the prevailing charge as it is currently calculated or by setting the maximum allowable fee at a lower percentile (e.g., 50th) of customary charges than that used to derive the prevailing charge (the 75th). This approach had been endorsed by the American Clinical Laboratory Association and by individual laboratories that had proposed fee schedules for a number of years. It is simple to understand and relatively easy to administer. Moreover, it offered the advantage of being least intrusive on the structure of the laboratory industry and physicians' current practice patterns. A fee schedule established on a carrier-wide basis could be used to limit the reasonable cost recognized by Medicare for tests performed in hospital outpatient departments. The major disadvantage identified by the Task Force was the concern that, without good data on laboratory-to-physician prices, the program could not readily select the appropriate percentage of the prevailing charge (or percentile of the customary charges). However, the American Clinical Laboratory Association had suggested that two-thirds of the prevailing charge was acceptable; the Task Force proposes that, since fees have continued to increases during our and the Congress's deliberations over laboratory reimbursement alternatives, 60 percent of the prevailing charge is an appropriate starting point. If desired, carriers could compare this figure to published laboratory prices and make adjustments where appropriate. On the basis of our evaluation, the Task Force thus recommends that carrier-wide fee schedules set at 60 percent of the prevailing charge for laboratory tests be the basis for payment by Medicare Part B.

How to adjust fee schedules in subsequent years warrants additional analysis of the rates of growth in the costs of services, changes in demand, in the technology for performing tests, and in the overall capacity of the laboratory industry. The market for laboratory services appears to be increasingly regional or national in scope, which suggests that aggregating from carrier-wide fee schedules to regional or national fee schedules may be appropriate. Lacking specific data on the costs of laboratory services and on the impacts of moving to regional or national fee schedules, the Task Force recommends that HCFA seek flexible authority to move toward national fee schedules as appropriate and to adjust payment rates no more frequently than annually.

Administrative simplifications

The Task Force believes that the final step needed to assure program and beneficiary savings is extensive effort to simplify claims processing requirements, particularly for independent laboratories. Among the changes proposed by the Task Force are: (1) deletion of the requirement for a diagnosis on independent laboratory claims, as long as the name of the referring physician is included on the bill; (2) requiring carriers to accept and process periodic billings for all of a laboratory's Medicare patients rather than requiring individual claims for each patient; (3) limiting the patient-specific information required to the minimum that will permit identification of the beneficiary; (4) instituting prompt payment practices; and (5) requiring carriers to provide, along with the explanation of Medicare benefits, the laboratory's invoice or specimen accession number to facilitate its reconciliation of Medicare payments with Medicare billings.

The Task Force believes that these procedural changes might be the most significant the Medicare program could make in order to capitalize on its role as a volume payer of laboratory and other medical services. While the program necessarily has to concern itself with identifying and eliminating instances of fraud and abuse and protecting the overall fiscal integrity of the program, the Task Force believes that instances of fraud and abuse should be viewed as the exception rather than the rule. Billing simplification need not undermine the program's ability to eliminate questionable practices. Rather, they might well eliminate some of the underlying reasons for such practices by reducing suppliers' costs of doing business with the Medicare program. Additionally, they represent a good faith effort to rationalize program payment in a manner that is to all parties' advantage. From this perspective, it may be useful to handle audit and program validation efforts by periodic sampling and linking of laboratory and physician claims, rather than maintaining cumbersome claims processing procedures to try to identify every questionable claim for diagnostic testing.

It is important to note here that the Task Force proposes adoption of its recommendations as an entire package. Medicare payment reductions of the magnitude proposed above without the other changes recommended by the Task Force (i.e., direct billing, waiver of coinsurance and deductible amounts on assigned laboratory claims, application of the fee schedule to all Part B suppliers of lab tests, and payment for specimen collection to whomever draws the specimen) are likely to yield program savings merely at the expense of beneficiaries. This is a result that the Task Force tried to avoid and believes need not obtain.

The Task Force's recommendations, if adopted with the current claim-by-claim assignment option, are estimated to yield Medicare Part B savings of $145 million in FY 1985, increasing to more than $600 million by FY 1989. Because assigned claims would be paid at 100 percent of the fee schedule with no coinsurance and deductibles, the savings associated with the mandatory assignment option are somewhat smaller, ranging from $115 million in FY 1985 to $570 million in the fifth year. Both alternatives would also generate Medicaid savings on the order of $35–60 million (Federal share) annually, since Medicaid would no longer have to pay beneficiary cost-sharing amounts for laboratory services to dual eligibles.

LIST OF TASK FORCE MEMBERS

Daniel A. Baker, Bureau of Program Operations; Charles R. Booth, Chairperson, Bureau of Program Operations; Betty Burrier, Office of Inspector General; Stanley Edinger, Health Standards and Quality Bureau; Richard Gerber, Bureau of Quality Control; George Greenberg, Office of Assistant Secretary for Management and Budget; Linda Magno, Office of Legislation and Policy; Paul Riesel, Bureau of Eligibility, Reimbursement, and Coverage; John Spiegel, Office of Executive Operations; and Rhonda S. Whalen, Office of Coverage Policy.

SUPPLEMENTAL STATEMENT OF THE AMERICAN CLINICAL LABORATORY ASSOCIATION

This statement is submitted on behalf of the American Clinical Laboratory Association ("ACLA"), a trade association of federally regulated independent laboratories. It supplements the April 16, 1985 statement of William C. O'Neil, President of ACLA. As ACLA noted in its initial statement, the Association opposes the proposed freeze on the Medicare laboratory fee schedule for four reasons:

First, laboratories have already sustained an overall reduction of 40 percent of the amounts that they previously received in payment for testing services provided to ambulatory Medicare beneficiaries as a result of enactment of Section 2303 of the Deficit Reduction Act of 1984 ("DRA"). Thus, laboratories have suffered large, actual reductions in Medicare payments, as opposed to cuts in the amount of increase in reimbursement levels sustained by other providers of health care.

Second, when Congress approved these reductions in laboratory payments, it promised an annual update of the fee schedules to help laboratories meet increasing costs.[1] Laboratories have made business plans and investments in reliance on this update. Because of the substantial reductions that laboratories have already incurred, it would be unfair to deny laboratories the promised increase.

Third, Congress mandated, as a quid pro quo for the DRA required reimbursement reductions, that the Health Care Financing Administration simplify the billing mechanisms that currently overburden and overtax both the Program and laboratories.[2] Despite this directive, to date HCFA has failed to adopt any simplification measures. To eliminate the promised fee schedule update in the face of the unfulfilled promise of billing simplification would tax laboratories with even deeper reimbursement cuts without any of the offsetting benefits that the DRA was supposed to guarantee. Moreover, it would be a breach of faith for Congress to freeze the laboratory fee schedules in the face of HCFA's failure to act and the statutory guarantee of an annual update of the fee schedule amount to reflect the percentage of increase (or decrease) in the Consumer Price Index.

Fourth, independent laboratory charges have not increased as quickly as the charges of other members of the health care industry. Thus, the proposed freeze will

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[1] The DRA provision states in relevant part that: "[T]he Secretary shall set the fee schedules . . . for the 12-month period beginning July 1, 1984, adjusted annually by a percentage increase or decrease equal to the percentage increase or decrease in the Consumer Price Index For All Urban Consumers (United States city average) . . ." Section 2303(d), amending Section 1833(h)(2) of the Social Security Act.

[2] The DRA provision directs the Secretary to: "[S]implify the procedures under Section 1842 of the Social Security Act with respect to claims and payments for clinical laboratory tests so as to reduce unnecessary paperwork while assuring that sufficient information is supplied to identify instances of fraud and abuse." Section 2303(h).

work an especially great hardship on independent laboratories, which represent one of the most competitive segments of the health care industry.

Despite ACLA's opposition to the proposed freeze, we are sensitive to the need to cut the federal deficit. Thus, ACLA submits this supplemental statement to propose four alternative measures, in lieu of the proposed fee schedule freeze. ACLA believes that, if implemented, these alternatives would reduce Medicare outlays for laboratory testing services. These proposals relate to the amounts that Medicare pays for testing services as well as incentives that currently exist for physicians to order more tests than may be appropriate or medically necessary.

First, ACLA recommends that Congress reduce the fee schedules applicable to hospital outpatient testing from 62% of prevailing charges to 60% of prevailing charges.[3] Such a reduction would set hospital outpatient testing reimbursement at the same level as services provided by independent and physicians' office laboratories as well as by hospital laboratories to non-patients.[4] ACLA has never understood the need for a higher schedule for hospital outpatient testing and believes that substantial reduction in Medicare outlays could be achieved by making hospital outpatient testing reimburseable pursuant to the same 60% fee schedule as applies to independent, physician office, and hospital non-patient laboratory testing.

In addition to these savings, the proposal is sound policy as it would result in site-neutral reimbursement, a concept endorsed by the Administration and long sought by ACLA. The principle underlying site-neutral reimbursement is that the same payment rules should apply to all providers and suppliers of the same service. To pay hospital outpatient testing at a higher fee schedule than applies to other laboratory testing services is to provide incentives for the provision of increased services by hospital outpatient departments. Medicare reimbursement policy should not provide any incentives that favor one segment of the market over another. Thus, in addition to achieving savings, this proposal would place all laboratory competitors on an equal footing.

The current Medicare laboratory policy creates incentives for physicians to engage in arrangements that lead to overutilization of testing services. Thus, ACLA's second proposal is that laboratory testing which is performed or supervised by physicians should be subject to the same mandatory assignment requirements that now apply to hospital and independent laboratories, as a result of the DRA.

Currently, hospital and independent laboratories must accept assignment of Medicare patients' rights to reimbursement and must directly bill the Program for those payments. In establishing these requirements, however, the DRA exempted laboratory tests performed or supervised by phsicians from the mandatory assignment provisions. This exemption has encouraged the formation of additional and more extensive physicians' office laboratories as well as shared service laboratories[5] to enable these physicians to continue to profit from laboratory testing because physicians may bill Medicare beneficiaries for services performed in physicians' testing facilities. This loophole allows physicians operating office laboratories to charge uncontrolled prices for laboratory tests with beneficiaries only receiving from the Program 80% of the fee schedule price.[6] Morever, because the absence of mandatory assignment requirements applicable to physician's office testing has led to the proliferation of office laboratories, increased utilization of testing by those physician lab operators is likely to occur. There is little doubt that physician involvement in testing tends to increase utilization because of the financial benefits that result from such testing.[7] Needless to say, when increased ordering occurs, Medicare outlays escalate.

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[3] The original House bill that the Ways and Means Committee approved and that led to the DRA called for a fee schedule set at 60% for all laboratory testing services provided to ambulatory Medicare beneficiaries. The Senate Finance Committee proposed the 62% fee schedule for hospital outpatient testiing.

[4] "Non-patients" are typically patients of physicians who choose to send specimens to a hospital for testing. In this situation the hospital laboratory acts like an independent laboratory. A "hospital outpatient" is one for whom the hospital maintains a hospital record and for whom hospital employees provide a service. Typically, a hospital outpatient goes to the facility for specimen collection and has some pre-existing relationship with the hospital.

[5] A shared service laboratory is a laboratory established by physicians who do not share a practice but who combine to form a laboratory to perform testing for the patients of the physician owners. HCFA has suggested that it may plug this loophole once it promulgates regulations implementing the discretionary portions of the DRA laboratory payments provisions.

[6] While this scenario does not result in increased outlays for the Program, it does injure beneficiaries. Thus, if a doctor charges a beneficiary $20.00 for a test that is listed on the fee schedule at $10.00, the beneficiary will only receive $8.00 from the Program and will owe the doctor $12.00.

Hand-in-hand with the loophole created by the absence of mandatory assignment is the puzzling fact that Medicare does not require that physicians' office laboratories comply with any of the quality assurance regulations applicable to other laboratories. Thus, Medicare exempts physicians' office laboratories from these standards. As a result, the expense that attends compliance with these regulations does not apply to physicians' office laboratories, and few barriers to entry exist for physicians wishing to continue earning profits from laboratory testing services. In addition, because of the absence of any quality assurance regulation, these physicians' office laboratories may perform at substandards levels creating the potential that disease will continue undetected. When illness remains undiagnosed, the costs of treatment, when diagnosis finally occurs, are usually higher than they would have been had the condition been diagnosed earlier.

Thus, ACLA's third recommendation is that the United States Congress enact legislation that would require physicians' office laboratories to be certified by the Medicare Program under the same regulations that apply to independent laboratories. Such a measure would assure that Medicare is receiving value for the monies it spends on testing performed in physicians' offices. Enactment of such a proposal would also discourage physicians from starting laboratories if the principal reasons underlying the decision to perform laboratory tests are financial rather than medical.

Finally, ACLA has observed that physicians who do not want to establish laboratories in their own offices but who do wish to profit from laboratory testing have been investing in laboratories (often called "captive laboratories") to receive profit distributions.[8] In general, these arrangements work as follows. An entrepreneur decides to offer physicians who refer laboratory testing the opportunity to invest in a laboratory. Many physicians are accepting such offers. Then the physician investors refer their testing to the captive laboratory. The captive laboratory in turn distributes profits to the investing physicians. These arrangements cannot help but induce physicians to overutilize testing services as the more the captive laboratory is used the greater the profit to be distributed to the physician investors. A recent May 9, 1984 report issued by Michigan Blue Cross and Blue Shield (a copy of which is attached hereto) confirms that physician investment in captive laboratories leads to overutilization. It concludes at p. 1 that "[t]he number of services per patient in the physician-owner lab group is . . . 20.97% higher than the average for all labs and . . . 39.65% higher than the average for non-physician owned labs." Thus, ACLA's fourth proposal is that the Medicare Program should disallow reimbursement to any laboratory for testing services performed on specimens sent to that laboratory by a physician-investor.[9]

ACLA believes that if all four of these recommendations are adopted, the Medicare Program will experience substantial cost savings without the necessity of a fee schedule freeze.

We look forward to working with the Committee on these proposals and will be pleased to provide additional information or respond to questions.

BLUE CROSS AND BLUE SHIELD OF MICHIGAN, MEDICAL AFFAIRS DIVISION

COMPARISON OF LABORATORY UTILIZATION AND PAYOUT TO OWNERSHIP

I. Background

This study was undertaken to identify the differences, if any, in average payment and average number of laboratory services per identifiable BCBSM patient on the basis of laboratory ownership.

II. Method

The claims data for all laboratory services for 3Q83 were reviewed for all independent laboratories (148) in the state of Michigan. The variables of —(1) Total Payment; (2) Total Number of Services; (3) Total Number of Patients; (4) Average Payment Per Patient; and, (5) Average Number of Services Per Patient, were identified for each of the 148 laboratories.

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[7] Physicians are in a unique position when they perform testing services as they control both demand and supply. The incentives to overutilize are obvious.

[8] ACLA is prepared to share with the Subcommittee specific information about how these arrangements work and how they are being marketed.

[9] ACLA is not the only voice to express concern about these arrangements. Others include the Federal Bureau of Investigation, Arnold Relman, M.D., Editor of the New England Journal of Medicine, the Michigan Medicaid Program, Region V of the Health Care Financing Administration and the States of New York and Michigan.

From this list, 20 laboratories known to have physicians (other than Pathologists) involved in ownership were selected as a sample and 20 laboratories known not to have physicians (other than Pathologists) involved in ownership were selected as the second sample. These two samples, totalling forty (40) labs, represent approximately two-thirds of the total payout and services rendered by the 148 labs in the state.

Table I lists the twenty (20) physican-owned laboratories showing Average Payout; Average Number of Services; Total Payout; Total Number of Services; and Total Number of Patients, for each individual laboratory.

Table II lists the twenty (20) non-physician-owned laboratories showing the same data elements.

Table III was designed to compare both samples to each other and to the total group.

The average payment per patient in the physician-owned lab group is $8.26 (22.59%) higher than the average for all labs and $19.34 (43.15%) higher than the average for the non-physician-owned labs.

The average number of services per patient in the physician-owned lab group is 1.08 (20.97%) higher than the average for all labs and 2.47 (39.65%) higher than the average for the non-phsician-owned labs.

The range for each of these elements for the two groups is compared below:

	Range			
	Average payment per patient		Average number service per patient	
	Low	High	Low	High
Physician owned	$21.33	$123.18	3.42	20.72
Nonphysician owned	7.15	30.33	1.67	4.68

III. Summary

Since referring physician could not be directly linked to laboratory work in the past, it is impossible to determine just how much of the laboratory testing in the physician-owned labs was requested directly by physician owners. However, the data does suggest that the overall utilization in a physician-owned laboratory is significantly higher (40%) than that seen in non-physician-owned labs.

	Payment per patient	Services per patient
Physician-owned	$44.82	6.23
Nonphysician owned	25.48	3.76

This study supports similar work undertaken by the Medicare Program Region V in May of 1983 which revealed a 34% higher payment level for patients receiving services from a physician-owned lab than for those receiving services from non-physician-owned labs.

TABLE 1.—PHYSICIAN-OWNED LABORATORIES 3Q83 (NONPATHOLOGIST)

Lab code	Average payout per patient	Average number services per patient
01	$34.10	4.82
02	58.02	7.35
03	89.12	9.80
04	52.00	7.65
05	36.21	5.24
06	52.87	7.75
07	87.84	11.82
08	32,09	5.56

TABLE 1.—PHYSICIAN-OWNED LABORATORIES 3Q83 (NONPATHOLOGIST)—Continued

Lab code	Average payout per patient	Average number services per patient
09	27.09	4.02
10	58.30	8.28
11	23.91	4.37
12	89.91	11.33
13	21.33	3.84
14	40.35	10.17
15	123.18	9.57
16	53.61	6.17
17	91.10	13.57
18	29.76	4.73
19	118.63	11.27
20	92.07	20.72
Average	44.82	6.23
Total payout		$4,962,856
Total services		689,339

TABLE II.—NONPHYSICIAN OWNED-LABORATORIES 3Q83 (LAY PERSON OR PATHOLOGIST)

Lab code	Average payout per patient	Average number services per patient
01	$27.28	3.76
02	23.42	2.84
03	28.18	4.56
04	24.96	3.94
05	22.76	4.07
06	18.85	3.31
07	30.33	4.53
08	28.25	3.92
09	10.93	3.26
10	21.88	4.20
11	18.31	3.15
12	21.13	2.80
13	12.40	2.18
14	16.85	2.41
15	27.82	4.68
16	7.15	2.18
17	9.87	1.99
18	19.37	2.98
19	31.50	1.67
20	25.96	1.95
Average	25.48	3.76
Total payout		$3,329.137
Total services		491,646

TABLE III.—COMPARISON: PHYSICIAN OWNED TO NONPHYSICIAN OWNED TO TOTAL

	Average payment per patient	Average services per patient	Total payout 3Q83	Total services 3Q83	Total patients
All independent labs in State (N=148)	$36.56	5.15	$12,082,842	1,700,752	330,507
Physician-owned sample of N=20	$44.82	6.23	$4,962,856	689,339	110,733
Percent of physician owned			41.07	40.53	33.50
Non-physician-owned sample of N=20	$25.48	3.76	$3,329,137	491,646	130,651
Percent nonphysician owned			27.55	28.91	39.53

TABLE III.—COMPARISON: PHYSICIAN OWNED TO NONPHYSICIAN OWNED TO TOTAL—Continued

	Average payment per patient	Average services per patient	Total payout 3Q83	Total services 3Q83	Total patients
Combined samples N=40			$8,291,993	1,180,985	241,384
Percent of combined samples			68.63	69.44	73.03

Mr. JACOBS. Thank you very much.

Mr. Linden.

STATEMENT OF SANFORD J. LINDEN, PRESIDENT, NATIONAL ASSOCIATION OF MEDICAL EQUIPMENT SUPPLIERS

Mr. LINDEN. Good morning, gentlemen. My name is Sanford Linden. I am the president of the National Association of Medical Equipment Suppliers and I am the owner of Linden Home Health Care.

NAMES truly appreciates the opportunity of being able to testify before this committee. And we also would like to support the administration budget proposal to freeze and index medical equipment prices as part of the overall effort to reduce budget deficits.

However, it must be done and considered in light of three major policy and reimbursement initiatives for Medicare medical equipment that have been recently implemented by the Health Care Finance Administration. These initiatives include oxygen coverage guidelines, oxygen reimbursement guidelines, and probably the most important, the rent purchase payment procedures.

I would like to give you a little bit of a synopsis about what we do in our industry and how it is becoming more difficult with regard to the DRG's and how the home health care industry has evolved to become more than just equipment and equipment rental type of service.

Gentlemen, we are called upon now by physicians, we are called upon by hospital discharge planners, to become problem solvers. I think certainly this is a change since 1965 when at that time we were called up to please deliver a wheelchair, please deliver oxygen to the patient's home. Now, because of the dependence of home care's success on our expertise in selecting equipment, in providing the service for that equipment, in maintaining that equipment, all of the things that we are called upon to do, it was very poor timing, in light of this dependence for HCFA to impose rental versus purchase on the purchase side.

Please allow me to explain. Up until now the patient in a rental situation of durable medical equipment can count on the industry to not only deliver and instruct and provide loaner equipment as well as any type of repairs and maintenance that is required. We are also called upon to exchange equipment when a diagnosis changes, as a patient's condition gets worse. This is all done at no extra charge.

But in light of the new proposals by HCFA, they are saying the service is not a part of it, the maintenance is not a part of it. We are just there to provide the equipment.

I think if you could look at a situation of your own with an elderly person who now is being called upon to refill their own oxygen cylinder within their home, which is a drastically dangerous type of position to take, if you are looked upon to look at the delivery system that at one time was put into effect and added on in terms of rental prices, now that is being taken away.

You can imagine what it is like for a senior citizen to go and pick up a hospital bed. You can imagine what it is like as part of our services under rental when we have delivered that hospital bed to go up and find another bed up there, to disassemble it and take it down to the basement so the new bed can be utilized. This is all being taken away under purchase.

I think that the written testimony that you have in front of you will explain our issues. I am hoping that if there are any questions, I can help answer them.

But I am very much in favor of the freeze if we can establish some purchase prices that are fair, marketable prices. Up until now there has been no history of purchase prices. We have been primarily a rental industry. All of our screens, history, and data have been based upon rental prices.

Now, because the February 1 rental purchase guidelines are upon us—which I might add was 13 days before a GAO report came out that showed purchase of expensive equipment was not cost effective—I think in light of all of these facts, let us first take the responsibility to get fair and equitable reimbursement prices for this very necessary component of home health care before we do make those freezes.

Gentlemen, I thank you.

[The prepared statement follows:]

STATEMENT OF SANFORD J. LINDEN, PRESIDENT, NATIONAL ASSOCIATION OF MEDICAL EQUIPMENT SUPPLIERS

SUMMARY

NAMES supports the Administration's budget proposal to freeze and index durable medical equipment charges as part of the overall effort to reduce the budget deficit.

The effect of the budget freeze proposal must be considered in light of three major policy and reimbursement initiatives for Medicare DME recently introduced and implemented by HCFA. These initiatives include oxygen coverage guidelines, oxygen reimbursement guidelines, and rent/purchase payment procedures. Other proposed Medicare initiatives are also expected.

The effect on Medicare beneficiaries of assignment, quality of products, and service on the equipment resulting from recent policy changes must be assessed. We project lower rate of assignment, lower quality products and decreased service on the equipment. Access to home care may also be jeopardized as smaller suppliers go out of business.

Congress must assure prior to implementation of the budget freeze proposal on purchase of DME that purchase charges have been established at levels that are consistent with marketplace prices. Purchase of DME before implementation of the rent/purchase payment procedure was a relatively rare occurrence in the Medicare program. Therefore, there are very few customary or prevailing purchase charges for new and used equipment. Where such purchase charges may exist they are fraught with significant errors and are hopelessly outdated.

NAMES believes savings could be achieved by withdrawing the HCFA rent/purchase instructions for expensive DME. Additional savings would result from implementing the NAMES alternative payment proposal. Savings from both actions—withdrawing rent/purchase for expensive equipment; implementing NAMES alternative—are documented in the February 13, 1985 draft GAO report on DME.

STATEMENT OF NAMES

Thank you, Mr. Chairman, for allowing the National Association of Medical Equipment Suppliers [NAMES] to present its views regarding the Administration's budget proposals for the Medicare program.

My name is Sanford J. Linden. I am President of NAMES and owner of Linden Home Health Care, Southfield, Michigan.

NAMES, with a membership of nearly 1,600, is the largest trade association representing home care medical equipment suppliers throughout the country. Our members serve over 2 million patients who are able to avoid institutionalization because of the availability of medical equipment ranging from walkers and wheelchairs to oxygen-related items to high tech nutritional therapy. Home care equipment suppliers provide not only the equipment but also the services that are essential to assure proper functioning and use of the equipment in the home. Most NAMES members serve Medicare beneficiaries.

We are joined in this statement by the Health Industry Distributors Association (HIDA), which represents the full range of medical product suppliers including distribution to hospitals, physicians and the home. HIDA will submit a separate written statement but has authorized NAMES to state that it is in agreement with the following comments concerning the provision of medical equipment for use in the home.

I. NAMES supports a DME freeze

Mr. Chairman, NAMES supports the Administration's budget proposal to freeze the customary and prevailing charges for durable medical equipment (DME) beginning in fiscal year 1986 and the CPI indexing for fiscal year 1987. We have not seen the actual proposed budget legislation. Therefore, we are not sure what is proposed to be frozen. Mr. Chairman, NAMES supports a freeze that applies to the lower of the supplier's data generated customary charge or the 75th percentile of the data generated customary charges for all suppliers in a given locality. This is referred to as the reasonable charge methodology and is set out in the Section 1842B of the Medicare statute.

The budget freeze proposal has been construed as a limit on increase, however, a true freeze would assure that prices cannot be lowered or raised.

Oxygen Reimbursement.—HCFA implemented on April 1, 1985, a nationwide system of limiting Medicare payment for oxygen under the DME benefit. The HCFA initiative (PATROL Transmittal No. 18-3) directs carriers to pay for all oxygen at a standard per cubic foot rate. This PATROL initiative was not subject to notice and comment through Federal Register publication or any other outside input. HCFA expects this initiative will achieve savings for Medicare. It will also cause beneficiary hardship particularly from the elimination of a fair price for portable gaseous oxygen. NAMES has requested along with doctors, manufacturers, and beneficiaries, that HCFA direct carriers to establish a separate pricing method for portable oxygen cylinders.

Unlike the portable liquid oxygen systems, portable gaseous oxygen cylinders cannot be transfilled in the home due to the extraordinary fire and explosion hazards associated with high pressure cylinders. There are significant and extensive federal regulations and industry safety procedures which must be met to transfill gaseous cylinders. It is beyond the technical and financial ability of most Medicare beneficiaries to meet these requirements and is certainly an error for HCFA, as a matter of policy, to establishment reimbursement rates on the assumption that a beneficiary can transfill in their home.

While NAMES supports efforts to achieve a reasonable balance in oxygen payment, reimbursement policy should not be used to restrain utilization—coverage guidelines serve that purpose. The proposed reimbursement for portable gaseous oxygen which is substantially lower than market prices is a barrier to beneficiaries' access to necessary and appropriate portable gaseous oxygen as demonstrated in HCFA Region IV.

Oxygen coverage.—The April 5, 1985, publication by HCFA of a final notice of oxygen coverage guidelines may result in reduced utilization of oxygen and, therefore, may result in additional Medicare savings. The oxygen coverage guidelines establish uniform, nationwide criteria which a beneficiary must meet to receive Medicare oxygen benefits. NAMES supports such an effort to bring predictability and consistency to oxygen coverage determinations.

Rent/purchase.—HCFA implemented on February 1, 1985, the DME rent/purchase guidelines. These carrier guidelines drastically revise the method for determining payment for DME by requiring purchase rather than rental. A closer examination of the data from the GAO's draft report reveals quite different savings outcomes for expensive and inexpensive DME. Therefore, at the outset we must distinguish between the rent/purchase policy change for inexpensive equipment (costing less than $120.00) and expensive equipment.

HCFA's action on implementing rent/purchase payment for inexpensive DME seems appropriate because it is likely to: (1) reduce Medicare outlays, (2) not increase claims administration expenses, (3) not disrupt Medicare beneficiary benefit for DME and, (4) resolve abuses of long term rentals of inexpensive equipment. NAMES has supported such action since 1982.

By contrast HCFA's action which increases purchase of expensive equipment (costing more than $120) is an egregious error because, according to the HCFA-Williams College and GAO reports it is likely to: (1) not reduce Medicare outlays, (2) increase claims administration expenses and (3) disrupt beneficiary service by eliminating routine maintenance and the DME benefit. Therefore, Congressional attention at this time must focus on HCFA's action on Medicare payment for purchase of expensive DME.

NAMES long-time position has been that reimbursement for items costing $120 or less should be limited to the purchase price. In addition, NAMES developed for expensive equipment an alternative reimbursement formula designed to eliminate abuses while recognizing the fact that the DME industry is labor intensive, service and maintenance oriented. The acquisition cost of DME is only a small percentage of the total cost of doing business. The NAMES payment alternative has been communicated to both the Congress and HCFA many times over the last two years.

Implementation of the rent/purchase guidelines for expensive DME has not gone well. Despite HCFA's claims that Medicare carriers and the DME industry have had two or three years to prepared for implementation—the plain fact is that carriers, beneficiaries and suppliers were unprepared. Today, more than two months after implementation, every DME supplier is uncertain about how his Medicare claims will be processed, what price will be used and when he will be paid. It is not just a few inefficient carriers who are having trouble—all carriers are having difficulty with implementation of DME rent/purchase guidelines. The problem? Unclear, inconsistent, and ambivalent instructions and directions from HCFA.

NAMES, carriers, and HCFA have been working together to develop clear and consistent implementation instructions. However, many of these implementation issues have been around since 1980 when the rent/purchase regulations were published. The prospects for clarity and consistency are dim without substantive changes in the statute. HCFA's decision to put a moratorium on oxygen equipment a month and a half after implementation illustrates the underlying problems. Paying only for the product without consideration for service needed to maintain the equipment in the home is shortsighted and leaves the beneficiary at great risk.

Despite these implementation problems and uncertainties, we feel it is important to note that beneficiaries have thus far been shielded from any uncertainty or anxiety related to their Medicare DME benefit. This is due to the professionalism and sincere care that home care DME suppliers provide Medicare beneficiaries.

As you can see from these examples, HCFA has made in an extremely short period of time significant adjustments to the Medicare DME benefit—any one of which is as significant to DME suppliers as the shift in hospital payment to DRGs. There are additional administration actions currently under consideration by HCFA that would have an additional impact on the DME and other Part B services. These include parenteral/enteral nutrition reimbursement, arbitrary reduction in rental charges to 1/10 of purchase charges and arbitrary reduction in oxygen concentrator charges.

It is important to note that none of these administrative initiatives as described above are subject to administrative or judicial review.

II. Establish reasonable and fair purchase charges

As a result of the rent/purchase guidelines implementation, most carriers are, for the first time, developing prevailing charges for purchase of used equipment and prevailing charges for purchase of new equipment. If purchase charges are frozen, it could create severe hardships for both beneficiaries and suppliers. HCFA has recognized this problem and instructed carriers to closely examine profile purchase charges to determine if they are significantly lower than marketplace charges and make necessary upward adjustments where appropriate. NAMES, therefore, urgently requests that this subcommittee ensure that the freeze takes this uncertainty into account. Because virtually all beneficiaries choose to rent rather than purchase equipment, carriers have not had sufficient historical submitted charge data to establish purchase prevailing charges. Moreover, carriers that have established new equipment prevailing purchase charges for certain equipment have mixed submitted purchase charges for used and new equipment, as well as non-commercial (i.e., beneficiary to beneficiary) sales. Therefore, virtually all prevailing purchase charges for new equipment are significantly lower than marketplace prices.

HCFA instructed carriers to arbitrarily establish used equipment purchase prevailing charges at 75% of the new equipment purchase prevailing charge. In other words, 75% of an incorrect charge. There is no statutory basis for HCFA to arbitrarily set used prevailing charges at 75% of new prevailing charge and NAMES has vigorously opposed such action.

HCFA's recently implemented rent/purchase guidelines for Medicare DME payment provide an incentive—waiver of coinsurance and 100% payment—for a DME supplier submitting charges for purchase of used equipment at 75% (or less) of the new equipment reasonable charge for the same item. A subsequent HCFA instruction directed carriers to arbitrarily establish used equipment purchase pervailing charges at 76% of the new equipment puchase prevailing—effectively eliminating the waiver incentive, not allowing "market" behavior to occur, and imposing an unfairly low payment level.

NAMES supports the incentive provision contained in the statute at 75%. We oppose establishing the used purchase prevailing at that same level (i.e., 75% of the new purchase prevailing charge). HCFA's apparent reason for using 75% to arbitrarily set used purchase prevailing charge is to protect the beneficiary. However the beneficiary is harmed, not protected, because his or her choices are decreased. There is no increase in Medicare DME outlays if the used purchase prevailing charge is set at a higher amount, for example 90% rather than 75% of the new equipment purchase level. In fact, there may be additional savings to the Medicare program.

Furthermore, if 90% rather than 76% is used, the beneficiary (particularly a beneficiary with supplemental insurance) would have an opportunity to purchase a higher valued item—and have the supplier take assignment. For example, a supplier may have in his or her inventory two used hospital beds. One is two months old, the other two years old. The supplier purchase price for the two month old bed is $900.00 while the two year old bed is $750.00. If the used purchase prevailing is set at 90% (e.g., $900.00), rather than 75% (e.g., $750.00), the beneficiary has the opportunity to purchase either bed and have the supplier take assignment on either choice. The beneficiary that could not afford or does not have supplemental insurance for the coinsurance amount could select the $750.00 bed and the supplier under assignment would receive the full amount and not have to collect coinsurance from the beneficiary.

By contrast, if the used purchase prevailing is set at 75%, (e.g., $750.00) as the guidelines currently require, the beneficiary that selects that $900.00 bed would have to pay the supplier the full amount on his own because the supplier would not take assignment.

III. Impact of recent HCFA actions on DME benefit

Mr. Chairman, the Congress and your committee should be apprised of the impact on assignment, quality and service within the Medicare DME benefit that results from the cost containment actions already taken by HCFA (i.e., oxygen reimbursement, oxygen coverage, rent/purchase payment). Summarized below is the possible impact:

Assignment.—Traditionally, Medicare beneficiaries have enjoyed a very high rate of assignment by DME suppliers. The February 13, 1985, draft General Accounting Office (GAO) report on durable medical equipment indicated that for the carriers GAO reviewed, the percent of rental claims assigned was 96.4 while the percent of purchase claims assigned was 32.8. One reason for the lower assignment rate for purchase may be that purchase prevailing charges were unacceptably low. Therefore, with the implementation of rent/purchase payment, which increases the incidence of purchase, with the carriers establishing purchase prevailing charges, and with the reduction of prevailing charges for oxygen equipment, it is likely that a decrease in the percentage of assigned claims will result.

Quality of product.—HCFA implementation of rent/purchase for expensive equipment (equipment costing more than $120) creates a powerful incentive to provide the least expensive product possible for purchase. The DME industry strongly objects to this incentive because the lower cost equipment is usually lower quality, and the beneficiary and the Medicare program will bear this burden. Under rental, the DME supplier has an incentive to maintain quality products which remain in service for a long period of time. This contrasts with purchase where the low Medicare prevailing charges forces the supplier to cut costs by providing lower cost—therefore lower quality—equipment. Lower quality equipment has a shorter product life, requires more repair & maintainence and may result in increased Medicare outlays under purchase.

This was demonstrated in a November 1984 Congressional Office of Technology Assessment case study which found that 1) the emphasis on price over performance in the reimbursement procedure has probably discouraged innovation, 2) cost comparisons are more meaningful if "total annualized costs," which includes maintenance and repair, are computed, 3) encouraging innovation may result in lower annualized costs. Neither the GAO report nor HCFA's assessment of the rent/purchase payment procedure includes this analysis.

Service, repair and maintenance.—Essential to the provision of DME in the beneficiary's home is the service which is necessary to keep the product, whether life-support or other DME, operating. Clearly the level of service varies according to equipment needs and beneficiary usage. Generally, the current rental charges reflect this variance while purchase charges do not.

The beneficiary, prescribing physician and referral source recognize the medical necessity of having the equipment delivered to the patient's home. Under current hospital discharge pressure this delivery may be required at any time (e.g., weekends, evenings) and the request for the equipment is frequently on very short notice. The supplier distribution network accommodates timely delivery. In addition, subsequent requirements for necessary disposable supplies are delivered. Current Medicare rental charges include the delivery component while most purchase charges do not.

After delivery to the patient's home, the equipment must be set-up and put in good working condition. This often requires more than simply unboxing a product and checking to see if it is working properly (calibration, etc.). For example, over 200 varieties of wheelchairs are available. The DME supplier uses his professional judgment to select the best product and make the necessary adjustments to meet the beneficiary's individual medical needs.

A thorough understanding of the equipment by the beneficiary is necessary to achieve the proper medical benefit from the equipment. Often this requires that the supplier repeat daily the instructions to the beneficiary and his family, followed up with periodic inquiries to assure the beneficiary is using the equipment properly. Like the first days at home with a new baby, the first days at home with new equipment are more difficult and require more intense training and attention. Ongoing training is as important as the initial training.

24 hour service.—As already discussed above, the initial delivery may be required at any time. This requires 24 hour service and emergency phone line by the DME supplier. More important, however, is the need, while the patient is using the equipment, for immediate response to service needs. The supplier has a strong incentive to provide 24 hour service to solve problems with equipment under rental. There is no incentive for 24 hour service under purchase.

Maintenance.—As noted in the preceding examples any maintenance required to keep the equipment operating efficiently is covered under the Medicare rental. Most suppliers schedule periodic visits to provide routine maintenance on equipment in addition to responding to user needs for maintenance. Under purchase, Medicare would not pay for routine maintenance so the likelihood of optimum performance and useful life of the equipment is diminished.

Calibration.—Certain equipment (e.g., oxygen concentrator, TENS) must be periodically calibrated to assure proper functioning of the equipment. If the equipment is rented, such calibration, like routine maintenance, would normally be performed on a regular schedule. There is no provision for Medicare payment for calibration if the equipment is purchased.

IV. Absence of review or appeal

Perhaps the most serious problem for the DME suppliers under the Medicare Part B program is the total absence of judicial and administrative review of HCFA determinations. As a result of a series of federal court decisions in 1984, the authority for judicial review under the Medicare program is limited to the appeal procedures set out in the Medicare statutes and regulations. Under the Medicare statute there is no judicial review available to Part B beneficiaries and providers. The only review available is through an administrative procedure called a fair hearing, and is conducted by an employee of the Medicare carrier. Under Medicare regulations, a fair hearing is not available if a denial of a claim is based on a HCFA guideline, letter, memorandum, regulation, notice, or other written communication.

Thus, the above referenced oxygen reimbursement and coverage initiatives, the rent/purchase guidelines or any of the thousands of pages of HCFA determinations under the Medicare Part B program are precluded from review by anyone, be it a court of law or an administrative fair hearing. NAMES believes this situation was not intended by the Congress when the law was passed in 1965, but results from a series of statutory amendments, regulations on the conduct of a fair hearing and court decisions. We believe this problem should be corrected by Congress.

V. Conclusion

NAMES supports the freeze and index proposal in an effort to restrain Medicare outlays. The DME industry has been subject to significant changes due to the recent HCFA initiatives to reduce costs for Medicare DME—oxygen coverage, oxygen reimbursement, rent/purchase payment for inexpensive equipment. Significant problems with the purchase charges for new and used equipment need immediate attention. This is because, until the implementation of rent/purchase payment, there simply were no, or very few, customary or prevailing purchase charges. Congressional action on expensive DME should focus on the NAMES alternative payment proposal. The recent draft GAO report demonstrated, unlike HCFA rent/purchase instructions for expensive equipment, that the NAMES alternative would result in savings to the Medicare program.

VI. Recommendations

Consider the significant changes affecting beneficiaries receiving DME that have resulted from the policy changes recently implemented by HCFA.

Consider the need to first establish fair and reasonable purchase charges for DME before freezing those charges.

Consider the savings that would be achieved by withdrawing the HCFA rent/purchase payment instructions for expensive equipment and substituting the NAMES alternative payment proposal.

Consider the need for Congress to provide review and appeal for Medicare Part B beneficiaries and providers.

Mr. **Jacobs**. Thank you, sir.

Ms. Buddi.

STATEMENT OF JOAN BUDDI, VICE PRESIDENT, AMERICAN FEDERATION OF HOME HEALTH AGENCIES, INC.

Ms. **Buddi**. I am Joan Buddi, the vice president of the American Federation of Home Health Agencies. I am also the administrator of a home health agency in North Broward in Tamarac, FL. And I am very pleased to have this opportunity to present testimony to the House Ways and Means subcommittee as you consider the fiscal year 1986 budget for Medicare.

At a time of increasing concern about the expenditure of Federal funds on health care, home health services represent a cost saving alternative to institutionalization for a large number of elderly and disabled Americans.

The Medicare home health benefit is inevitably growing as the home health care industry develops the ability to cope with more and more complex cases, more physicians become aware of its benefits, and Federal policy such as prospective payment for hospitals encourages deinstitutionalization. Unfortunately, the Health Care Financing Administration is hindering the ability of home health agencies to deliver the services patients require to remain outside of institutions.

In recent months we have received reports of sharp increases in home health denials on claims that clearly appear to meet Medicare coverage requirements. Visits are being denied to severely ill patients. We believe this is part of a deliberate scheme to force home health agencies to cut back on visits even though based on good medical practice the visits should be made. This pattern is similar to the action of the Social Security Administration several years ago in removing hundreds of thousands of seriously disabled beneficiaries from the disability roles in a misguided attempt to save funds.

Over the last 2 years we have seen a series of actions on the part of HCFA which illustrate an adversarial attitude. HCFA has attempted to redefine the definitions of homebound and intermittent, proposed in effect elimination of waiver of liability, developed massive new reporting requirements, and restricted the ability of providers to represent patients in the appeals process.

HCFA is now proposing in its fiscal year 1986 Medicare budget a $4.80 copayment on all home health visits after the 20th and a restructuring of the home health cost limits.

The administration projects a savings of $65 million in fiscal year 1986 by requiring patients to pay $4.80 for each home health visit after the 20th in a calendar year. We believe that this proposal would further burden the very beneficiaries who are the sickest and the most in need of home care services.

It is the patients with the most serious illnesses, such as cancer and severe cardiac conditions, who need more than 20 visits and would have to make the copayments. The payments may cause them to refuse badly needed health care and reduce the incentive for them to stay out of hospitals. If this occurs, there will be a much greater cost to the Medicare Program in the long run.

The savings projected for the proposal are more apparent than real. Copayments that cannot be collected will be reimbursed as bad debt. Efforts to collect the relatively small amounts of money involved would add to administrative expenses which are reimbursable. If providers use collection agencies to recover debts, those costs are also paid under Medicare.

The administration further proposes to save $70 million in fiscal year 1986 through a restructuring of the home health cost limits. Although details of how these savings will be achieved have not been revealed. HCFA Administrator Dr. Carolyne Davis indicated recently that HCFA plans to apply the cost caps by discipline rather than in the aggregate.

At present agencies over the limits for one type of service can absorb the loss if they are under caps in other disciplines. Home health agencies will be forced to abandon high-cost disciplines if unable to recoup losses with below cost services, thus curtailing the access of beneficiaries to the care they need.

Forces outside the control of providers—competition for skilled personnel in urban areas and the need to attract and retain therapists in rural areas—most often cause agencies to exceed these caps.

We believe that HCFA is also planning to reduce home health reimbursement by lowering the current 75 percentile cost limit or else entirely restructure the method of calculation. It would create serious financial hardship for many providers if these limits are reduced just as they are seeing sicker patients requiring visits of a longer duration enter into the system.

The problem will be exacerbated since the health inflation index remains at around 7 percent and HCFA and its fiscal intermediaries persist in imposing layer upon layer of administrative burdens on providers of home health care.

Cost limit restructuring combined with elimination of waiver of liability may force many home health providers out of business. If noninstitutional services are not available in their communities Medicare patients would have to seek more costly institutional care at a much greater cost to the American taxpayer.

At a time of deregulation and getting Government off the backs of the American people, it does not make sense to pursue policies that place unreasonable and unnecessary burdens on agencies trying to provide good quality care for disabled and elderly beneficiaries who need health services to remain in their homes.

We urge the House Ways and Means Subcommittee to reject HCFA's home health copayment proposal, investigate the implication of restructuring the home health cost caps at a time when seriously ill patients are being discharged from hospitals, and encourage home health care as a cost saving alternative to institutionalization rather than restrict its availability at a time it is needed most.

Thank you.

[The prepared statement follows:]

Statement of Joan Buddi, Vice President, American Federation of Home Health Agencies, Inc.

My Chairman, my name is Joan Buddi. I am the Vice President of the American Federation of Home Health Agencies. I am also Administrator of Home Health of North Broward in Tamarac, Florida. I am very pleased to have this opportunity to present testimony to the House Ways and Means Health Subcommittee, as you consider the FY 1986 budget for Medicare.

At a time of increasing concern about expenditures of Federal money on health care, home health services represent a sensible cost-saving alternative to institutionalization for large numbers of elderly and disabled Americans. Home health care can shorten hospital stays and preclude institutionalization. Just as significantly, it can expedite recovery and enhance personal dignity by enabling individuals to maintain normal family life and useful functional activity.

The circumstances under which Medicare patients receive home health care are tightly controlled by law and regulation. Elderly and disabled Americans are eligible for the benefit if they are under the care of a physician, are confined to home, and require intermittent skilled nursing services or physical or speech therapy. The home health benefit is inevitably growing as the population ages; home health agencies develop the ability to care for more and more complex cases; more physicians become aware of its benefits; and Federal policies, such as prospective payment for hospitals, encourage the use of non-institutional services. Unfortunately, the attitude of many in the Federal Government, including some charged with administering the Medicare program, is not always positive toward home health care. We find the greater use of home care services, stemming from the factors I have mentioned, cited as justification for excessive stringency in the interpretation of regulations governing the program. We believe it makes no sense to pursue policies which encourage deinstitutionalization while hindering the ability of home health agencies to deliver the medically necessary services patients require upon discharge.

Some Federal officials continue to question the cost effectiveness of home health care, saying they are waiting for the findings of this or that study to tell them what we and private insurers, who increasingly recognize the cost saving implications of health care in the home, already know: home health care is cost effective.

The Health Care Financing Administration seems intent on following in the footsteps of its sister agency, the Social Security Administration, in arbitrarily denying valid claims. A few years ago, the media brought to light that the SSA had, without basis, removed hundreds of thousands of seriously disabled beneficiaries from the Social Security disability roles in an attempt to save funds.

In recent months, AFHHA has received reports from different areas of the country of a sharp increase in home health claims denials. These denials appear to follow a pattern similar to SSA's pattern in the disability area. Claims are denied that appear clearly to meet Medicare's coverage requirements. One can only surmise that HCFA is attempting to create a climate of uncertainty for HHAs in the hope that rather than risk disallowances, they will arbitrarily cut back on the frequency of service. Visits are being denied to severely ill patients without explanation, for no apparent reason. We can only conclude that this constitutes a deliberate plan to send a message to HHAs that they have to cut back on the frequency of visits even though based on good medical practice the visits should be made.

It appears that the sudden upsurge in denials being experienced around the country is part of some larger scheme that cannot be explained as a chance happening. We believe HCFA is cutting back on the home health benefit by denying more and more visits and attempting to discourage HHAs from giving more than the bare minimum number of visits.

In addition to massive denials, over the last two years we have witnessed a series of actions on the part of HCFA and its fiscal intermediaries which illustrate their adversarial attitude towards the home health benefit. Acting with little or no consultation with affected providers and consumers, HCFA has:

Attempted to change the rules to redefine homebound and intermittent in order to restrict the availability of home health services; proposed regulations to eliminate in effect waiver of liability; developed a massive new "minimum" data elements reporting requirement for all home health agencies; restricted patients' right to appoint providers to represent them in the appeals process; and made significant changes in coverage policy without revision to the Health Insurance Manuals.

Now as part of this pattern in its FY 1986 budget, HCFA proposes:

Imposition of a $4.80 copayment on all home health visits after the twentieth and a restructuring of the home health cost cap limits.

We will focus on the two FY 1986 budget proposals, in keeping with the topic of today's hearing.

COPAYMENTS

The Administration projects a savings of $65 million in FY 1986 and $590 million between Fiscal Years 1986 and 1990 by requiring patients to share the cost of more health services. Beneficiaries would be charged one percent of the inpatient hospital deductible for each visit after the 20th in a calendar year. This would equal $4.80 in 1986.

We believe that implementation of this copayment would have a detrimental effect on Medicare beneficiaries without resulting in significant savings to the Medicare program.

The coinsurance provision would impose an additional fincancial burden on the elderly who are already experiencing severe hardship because of previously enacted Medicare cuts and the rise in the cost of food, uitilities, housing, transportation, and other items. Along with health services, these necessities consume the bulk of the income of elderly Americans.

Currently, senior citizens are paying for 36 percent of their own medical expenses, and are now spending more of their income on health care than they did before the enactment of Medicare in 1965. By the time the typical Medicare beneficiary receives home health services, he or she has been hospitalized, incurred significant physician bills, required medications, and may have been a inpatient in a nursing home. Thus the typical patient has had to meet the Medicare hospital deductible of $400.00 and a Part B deductible of $75.00, has had to pay 20 percent of the Medicare-determined reasonable charges for physicians' services (where the physician accepts assignment, and an even greater proportion on unassigned charges), has paid for all drugs and medical supplies, and if in a nursing home under Medicare, has been hit with a $50.00 per day copayment on the 21st to the 100th day. While an additional $4.80 copayment on home health visits may seem small, to those who must struggle to meet their present obligations, it would be formidable.

There is no evidence that cost sharing would discourage any overutilization of the home health benefit. There may some cases of overutilization. This is no reason to impose additional financial burdens on the very beneficiaries who are the sickest and most in need of home care services.

In the last several weeks, we have talked to nursing supervisors at a number of large home health agencies. Without exception, they states that the imposition of a home health copayment would have an extremely detrimental effect on the well-being of their patients. They indicated that beneficiaries who require services on a long term basis are the most severely ill, unstable patients—those with cancer or serious cardiac conditions for example—who simply cannot manage a non-institutional existence without supportive home health services. It is these beneficiaries who need more than twenty visits and would be subject to the copayment provision.

A home health copayment will cause many elderly and disabled patients to refuse badly needed health care rather than incur additional debt. Having prematurely terminated home care services, these beneficiaries will be at high risk of requiring hospital or nursing home care.

With the advent of DRGs, patients are being discharged from hospitals at a more acute stage of their illness, and therefore require more intensive home health care. Rather than fostering recovery and a return to self sufficiency, coinsurance will reduce the incentive for patients to stay out of hospitals. We can expect to see many frail beneficiaries enter a "revolving door" syndrome: hospitalization, followed by a brief period of home care, followed by rehospitalization, and so on, with ultimately a much greater cost to the Medicare program.

The savings the Administration projects for the copayment proposal are more apparent than real. Under Medicare statutory and regulatory provisions, copayments that cannot be collected from beneficiaries will be reimbursed as bad debt. Section 1861(v) of the Medicare Act precludes providers from shifting the cost of services provided to Medicare beneficiaries to other patients.

In addition, the copayment proposal would place an administrative burden on home health agencies to collect relatively small amounts of money. Notwithstanding that the amounts to be collected for each patient will be relatively small, the cost of collecting $50.00 in coinsurance is as great as the cost of collecting $500.00. To establish that a copayment is uncollectable, home health agencies must attempt several collection efforts including telephone or personal contract with the patient or individual responsible for the patient's bills. These efforts to collect add to the agencies' administrative expenses which are Medicare reimbursable. Moveover, Medicare regulations permit providers to use collection agencies for uncollected coinsurance. The administrative expenses of colleciton agencies are also reimbursable under Medicare.

COST CAP RESTRUCTURING

The Administration proposes to save $70 million in FY 1986 and $480 million from FYs 1986 to 1990 through a restructuring of the cost caps for HHAs. Under current policy, reimbursement for home health services is limited to the 75th percentile of the cost of services provided by all agencies. The caps are figured separately for each discipline but are applied in the aggregate.

The projected savings are incorporated into the Administration's budget although the details have not yet been revealed. We understand that the regulations will be forthcoming shortly.

In recent testimony before another Congressional committee, HCFA Administrator Dr. Carolyne Davis indicated that HCFA plans to apply home health cost limits by discipline rather than in the aggregate. We also understand that HCFA and the Office of Management and Budget plan to ratchet down the current 75th percentile, or move to a new method of calculating limits in order to realize the projected $480 million in savings.

If cost limits are lowered and applied separately by discipline, some home health agencies may find admission of acutely ill patients a burden they are unable to bear, especially if they have experienced denials on similar cases and HCFA succeeds in eliminating the waiver of liability protection.

We fear that a per-discipline application of the cost limits will lead to a loss of access to home care services for many Medicare beneficiaries. At present, agencies which find they are over the limits for one type of service, such as physical or speech therapy, can absorb the loss if they are under the caps for other disciplines. If a per-discipline approach is instituted, many home health agencies that now provide a discipline at a loss will be unable to continue to provide that type of care.

In urban areas, if there is a shortage of trained personnel in a particular skilled field, providers, including hospitals and nursing facilities, will bid up the price of that service. The per-discipline approach will create particularly acute problems in non-urban and underserved areas, where agencies are faced with the problem of attracting and keeping skilled personnel. Providers may have to offer higher rates and employ personnel who have less than a full time load to insure that care is available when beneficiaries need it. The salaries these agencies have to pay to attract and retain the services of skilled therapists will force them above the cost cap limit for a particular discipline. If unable to recoup losses with other below-cap services, they will be forced to abandon the high cost discipline, curtailing the access of beneficiaries to services in those areas. Since HHAs are cost reimbursed, most are unable to make up disallowances for over-cap services.

Cost limits are based upon the historical cost of providing home health services. We believe that HCFA is now planning to discard the current 75th percentile limit and move to a lower percentage cap or restructure entirely the method of calculation; however HCFA has not involved the home health industry in discussions about this crucial issue.

A recent preliminary GAO report to Senator John Heinz indicates that Medicare patients are leaving the hospital in a poorer state of health. We believe that it would be a great mistake to lower the limits just as home health agencies are seeing sicker patients entering into the home health care system. Medicare does not allow a higher level of reimbursement for visits of a longer duration required by more severely ill patients.

We anticipate serious financial problems for many home health agencies if reimbursement is ratcheted down while the helath inflation index remains at around seven percent. These burdens will be exacerbated if HCFA and its fiscal intermediaries persist in imposing layer upon layer of administrative requirements on home health providers, for example through the requirement that HHAs supply extensive "minimum" data element information on each patient beginning August 31, 1985. Additional costly labor and paperwork burdens combined with inflation in rent, utility, transportation and other costs will place providers in an untenable position if HCFA significantly reduces the cost limits.

In addition, many HHAs will shortly be incurring transfer expenses as HCFA implements the provisions of the Deficit Reduction Act of 1984 reducing the number of fiscal intermediaries servicing home health providers to no more than ten. For a period of time, costs associated with these transfers may force agencies over the limits. Combined with the cost limit restructuring and elminiation of the favorable waiver of liability presumption, this will spell serious financial hardship for many agencies. HHAs whose costs are not reimbursed cannot remain in business. If noninstitutional services are not available in their communities, Medicare patients will have to be retained in hospitals, at great expense to the Medicare program.

Medicare providers are being buried in a sea of unnecessary papework and excessive bureaucracy. The red tape stranglehold on home health agencies belies HCFA's stated concern for access to services and quality of care. At a time of deregulation and getting government off of the backs of the American people, it does not make sense to pursue policies that place unreasonable and unnecessary burdens on agencies trying to provide good quality home care for disabled and elderly Americans who need the services to remain in their own homes. Curtailment of non-institutional health care is a great disservice not only to Medicare patients but also to the American taxpayer.

Mr. Chairman, we urge you and this Subcommittee to:

Reject HCFA's proposal for a home health copayment; invesitgate the implications of restructuring the home health cost limits at a time when more seriously ill patients are being discharged from hospitals; and act to encourage home health care as a cost-saving alternative to institutionalization rather than restrict the availability of non-institutional services at the very moment they are needed most.

Mr. JACOBS. Thank you.

Ms. Cushman.

STATEMENT OF MARGARET J. CUSHMAN, EXECUTIVE VICE PRESIDENT, VISITING NURSE & HOME CARE, INC., WATERBURY-HARTFORD, CT, AND CHAIRMAN, GOVERNMENT AFFAIRS COMMITTEE, NATIONAL ASSOCIATION FOR HOME CARE

Ms. CUSHMAN. Mr. Chairman and members of the subcommittee, I am Margaret Cushman, the executive vice president of Visiting Nursing & Home Care, Inc., serving Greater Waterbury, CT, chairman of the Government Affairs Committee, and secretary of the board of directors of the National Association for Home Care.

The National Association for Home Care represents approximately 3,000 members, including large and small home health agencies, freestanding hospital and nursing home-based agencies, visiting nurse associations, major corporate chains, homemaker home health aide agencies, and hospices.

We are very pleased to have the opportunity to present our views on the budget proposals today. In the interest of time, I'll summarize my statement and submit my written testimony for the record. Very briefly, I would like to address the proposal to freeze the home health cost limits. We feel that the cost limit increases should keep pace with inflation.

However, our testimony will not dwell on that issue. Our testimony will focus on the effects of the proposed copayment on the beneficiaries of Medicare.

The home health copayment to be imposed on Medicare beneficiaries is proposed to be $4.80 per visit for every visit after the 20th visit in a calendar year. We have three major reasons for opposing this. There is an unfair increased burden on Medicare beneficiaries. There is a lack of sound rationale for this proposal. And it would limit the use of home care as a free choice in the Medicare system.

I would like to expand on each of these reasons. Medicare beneficiaries are already required to pay the deductible and coinsurance liability for both part A and part B of Medicare. Beneficiaries must bear the expense for noncovered services and products including long-term care, prescription drugs, eyeglasses, hearing aids, and dentures. Few physicians accept Medicare assignment.

Thus, beneficiaries must pay the additional expenses above what Medicare pays out of pocket. And they must also pay premiums for part B coverage. The current structure of Medicare covers less than half of the beneficiaries' total health care bill. It is important to note that beneficiaries now spend about 15 percent of their income on medical care—the same percentage of their income as was spent before the creation of Medicare. By the year 2000, using conservative estimates, out-of-pocket expenses are likely to reach 20 percent of income.

The administration has proposed on top of these existing burdens many additional costs to beneficiaries which you have been hearing about today. We have serious reservations about the combined effect of these proposals. If they are enacted, we feel that they will not result in a comprehensive or a high quality system. They ignore the need to restructure the system into the continuum of health and instead simply cut expenditures.

We believe this is unwise and will eventually backfire on all of us. Specifically the proposal to initiate coinsurance for home health care after the 20th visit for Medicare beneficiaries is contradictory to the goal of discouraging excessive utilization of institutional placement.

Several congressional actions in the past few years have actually removed some of the restrictions on home health care as a benefit, and we would be penny wise and pound foolish to reverse this trend.

Second, far from saving millions of dollars, coinsurance will actually result in increased costs to Medicare. As you have heard from the previous testimony, the administrative expenses resulting from the necessity of billing for the copayment will increase the cost of Medicare services directly through the cost of a visit.

In addition, those copayments which are not collected from the beneficiary will be paid as bad debt to home health agencies. There has been some expression of the concern about overutilization of health care benefits and a belief that coinsurance would curtail misuse. The Government's own statistics show that over 4.9 million Americans are currently going without home care or supportive services that they need.

The Heritage Foundation summed up the advantages of increased utilization of home care in its December 1984 report, Mandate for Leadership: "widening use of home health programs * * * would reduce cost considerably".

Simply stated, the increased out-of-pocket costs to Medicare beneficiaries resulting from copayments will present a real barrier to care for those who simply cannot afford to pay.

There is a lack of sound rationale for the copayment proposal. It is based upon the assumption that there has been a substantial increase in the visits per beneficiary.

In fact, the statistics show that there has been an increase in the number of beneficiaries using home care which has virtually offset the increased number of visits. This home care growth is consistent with the policy that Congress was supporting in limiting some of the restrictions on home care in the 1980 Reconciliation Act, such as the elimination of the 3-day prior hospitalization requirement.

Finally, we have been working with the Health Care Financing Administration over the past year and certainly appreciate the need to streamline the home care delivery system while ensuring the delivery of quality care. We feel that copayment will actually increase expenses, not decrease them.

Thank you.

[The prepared statement follows:]

STATEMENT OF MARGARET J. CUSHMAN, MSN, R.N., EXECUTIVE VICE PRESIDENT, VISITING NURSE & HOME CARE, INC., WATERBURY-HARTFORD, CT, ON BEHALF OF THE NATIONAL ASSOCIATION FOR HOME CARE

SUMMARY OF PRINCIPAL POINTS

(1) We do not believe the proposal to freeze home health cost limits is necessary. Cost limits should, at a minimum, keep pace with annual inflationary increases in labor, goods, and services, as has been HCFA's policy in the past.

(2) We strongly oppose the proposal to impose a copayment on Medicare beneficiaries equal to $4.80 per visit for all home health visits after the 20th visit in each calendar year. The three major reasons are:

1. *Unfair increased burden on Medicare beneficiaries.*—Medicare beneficiaries are already required to make significant out-of-pocket expenditures to finance their own health care. Imposing a new co-payment for home health visits would increase the financial burden on beneficiaries and would result in patients going without needed home care or in unnecessary hospitalizations.
2. *Lack of sound rationale for the proposal.*—The imposition of copayments is erroneously predicated on the assumption that they will encourage more cost-conscious behavior on the part of beneficiaries. While home care costs to Medicare have increased somewhat, they still represent only approximately 2 percent of the Medicare budget and approximately 1 percent of the Medicaid budget.
3. *Lack of true and equal free choice between home health and institutional care utilization.*—There are already significant limits on home health utilization such as requirements that care be "intermittent," "medically reasonable and necessary," and that the patient be "homebound." No similar restrictions exist for institutional care benefits. To impose co-payments for home health without lifting existing utilization limits places home care providers at a competitive disadvantage.

STATEMENT

Mr. Chairman and Members of the Committee: My name is Margaret J. Cushman. I am the Executive Vice President of Visiting Nurse And Home Care, Inc., located in the Waterbury-Hartford region of Connecticut. I am here in my capacity as Chairman of the Government Affairs Committee and Secretary of the Board of Directors for the National Association for Home Care (NAHC).

The National Association for Home Care is the nation's largest organization representing home care and hospice providers and individual home care professionals and paraprofessionals. NAHC's nearly 3,000 members include large and small home health agencies, freestanding, hospital and nursing home-based agencies, Visiting Nurse Associations, major corporate chains, homemaker-home health aide agencies, and hospices.

I am very pleased to have the opportunity to present NAHC's views on the budget proposals under consideration by Congress which will seriously impact both home care providers and Medicare beneficiaries.

First, I would like to briefly address the proposal to freeze the home health cost limits. We expect that this freeze will be incorporated into the impending cost limit regulations to be issued by the Health Care Financing Administration (HCFA). In principle, as a professional organization representing primarily small businesses, we believe the cost limits should, at a minimum, keep pace with the annual inflationary increases in labor, goods, and services which our member agencies have to deal with. This has been HCFA's policy in the past. We believe it has been equitable and see no reason to reverse that policy and impose a freeze.

I would like to devote the bulk of my testimony to the proposal to impose a copayment on Medicare beneficiaries equal to $4.80 per visit for every home health visit after the 20th visit in a calendar year. The National Association for Home Care has three major reasons for our opposition:

1. The unfair increased burden on Medicare beneficiaries.
2. The lack of a sound rationale for the proposal.
3. The lack of a true and equal free choice between home health and institutional care utilization.

Let us examine each of these in greater detail.

1. Unfair increased burden on Medicare beneficiaries

Consider the existing financial contributions already made by beneficiaries to finance their own health care as a result of the current structure of Medicare:

Beneficiaries are required to pay the deductible and coinsurance liability associated with both Parts A and B of Medicare, both of which have steadily increased over the years. In 1983, for example, more than $8 billion was spent to meet Medicare cost sharing requirements—a 50% increase since 1981.

Beneficiaries must bear the expense for those non-covered services and products, such as long-term care, prescription drugs, eye-glasses, hearing aids, and dentures.

All too few physicians accept Medicare assignment. Thus, beneficiaries are liable for all charges over and above what Medicare pays. This liability for unassigned claims has dramatically increased.

Beneficiaries must also pay premiums for Part B coverage. This year, annual premiums will total $186—a 116% increase since 1977. In addition, many individuals recognize the shortcomings and limitations of Medicare coverage. Those who can afford it, often pay additional premiums for "Medigap" insurance policies.

A 20% coinsurance on durable medical equipment obtained through Part A home health providers is another example of out of pocket costs which were recently imposed in July 1984 under the Deficit Reduction Act.

The current structure of Medicare covers less than half of the beneficiaries' total health care bill. It is important to note that beneficiaries now spend about 15% of their income on medical care—the same percentage of their income as was spent before the creation of Medicare! And by the year 2000, using conservative estimates, out of pocket expenses are likely to reach 20% of income—and much more if additional premium amounts or copayments are required.

On top of these existing burdens, the Administration has proposed additional burdens on beneficiaries for fiscal year 1986 and beyond, including:

A freeze on Social Security COLAs.

A $4.80/visit copayment for each home health visit after the 20th visit in calendar year.

A gradual increase in the Medicare Part B premium over the next five years raising it to $16.80/month in calendar year 1986—a $1.30/month or $15.60/year increase over the current $15.50/month premium.

Changing Medicare eligibility to begin eligibility on the first day of the first full month in which the beneficiary is age 65. Currently eligibility begins on the first day of the first month in which the beneficiary attains age 65.

Beginning in 1987, index to Part B deductible to the Medicare Economic Index, raising the level from the current $75 to $78 in 1987.

Reducing Federal Medicaid expenditures for a reduction of $1.3 billion in federal funds in fiscal year 1986.

NAHC has serious reservations about the singular or combined effect of these proposals. Those who are currently eligible for Medicare benefits and those who will become eligible in the near future have planned for their retirement under the assumption that certain Medicare benefits will be available and that Social Security will at least keep pace with inflation through COLAs. Given these facts, the proposals are intrinsically unfair and represent a breach of faith to the elderly of this nation who have contributed to these systems throughout their working lives. The proposals, if enacted, will not result in a comprehensive or a high quality system. They ignore the need to restructure the system into the continuum of health care. Rather, they seek to cut expenditures and raise revenues in a "hunt and peck" manner. We believe this is not only unwise, but that this approach will surely backfire on us all.

Specifically, the proposal to initiate a requirement for coinsurance for home health care after the 20th visit for Medicare beneficiaries is totally contradictory to the goal of discouraging excessive utilization of institutional placement. Congress has taken several specific actions toward achieving this goal in the past few years, and we would be penny-wise and pound-foolish to reverse this trend. For example, the result of discouraging home care by the imposition of coinsurance will certainly be that those who are being discharged early due to the DRG system will fail to adequately recuperate and will simply return to the hospital or nursing home.

Secondly, far from saving millions of dollars, coinsurance will result in increased costs to Medicare. Home health agencies and/or the government will be put in the position of collecting coinsurance from the elderly. The administrative costs in doing so will be enormous, and will necessarily be passed along to Medicare. Also, as Dr. Carolyne Davis pointed out in her April 1st testimony before this Subcommittee, Medicare will have to cover the cost of non-paying beneficiaries by reimbursing agencies under the bad debt allowance. This will more than offset any savings which are anticipated from the implementation of coinsurance.

Some have expressed a concern about the overutilization of home care benefits and believe coinsurance will curtail this misuse. We reject this premise, and in fact the government's own statistics show 4.9 million Americans going without the home care or supportive services they need. The Heritage Foundation summed up the advantages of increased utilization of home care in its December 1984 report, Mandate for Leadership: "widening use of home health programs . . . would reduce cost considerably." Simply stated, the increased out of pocket costs will constitute a real barrier to quality care for those who simply cannot afford to pay.

2. Lack of a sound rationale for the copayment proposal

We have read in Secretary Heckler's fiscal year 1986 budget proposal that the copayment proposal is necessary "To encourage more cost-conscious behavior on the part of beneficiaries, while still ensuring that needed services are obtained" (page 35, February 4, 1985, HHS Release). In addition, the Secretary claims there is a need for more cost-conscious behavior because Congress in 1980 opened up the home health benefit, creating "a substantial increase in the use of home health services." To quote the Secretary:

"Under current law, there are no cost-sharing requirements associated with the use of home health services. The Omnibus Reconciliation Act of 1980 eliminated several restrictions and limitations on the use of home health services, such as the three-day prior hospitalization requirement, and the 100-visit limit under Part A and the deductible requirement under Part B. The repeal of these limits appears to have resulted in a substantial increase in the use of home health services. From 1978 to 1980, the annual rate of increase in the number of visits per 1000 enrollees was in the range of 7 to 12 percent. In 1981 and 1982, it increased to 14 and 16 percent respectively."

We believe the Secretary is proceeding on false assumptions about the reasons for the increased number of persons using home health, increased number of visits, and increased outlays. Let's look at some actual facts.

First, there has not been "a substantial increase" in the number of home health visits per beneficiary per year. The increased number of persons using the Medicare home health benefit has virtually offset the increased overall number of visits. For example, between 1978–1982 the number of persons using the Medicare home health benefit increased from approximately 770 thousand to 1.2 million. During the same period, the total number of visits increased from about 17 million to about 31 million. Yet in 1978 the average Medicare home health beneficiary received only 22.5 visits/year compared to 26.3 visits/year in 1982. More specifically, in 1980 (the year cited by the Secretary) the average was 23.4 visits per year compared to 26.3 in 1982.

Second, while overall Medicare reimbursements for home health have increased substantially, there has not been an appreciable increase in the average Medicare payment per home health visit. In 1978 Medicare reimbursements for home health were about $427 million; in 1980 about $662 million; and in 1982, about $1.2 billion. That's nearly a 200 percent increase from 1978–1982 and a 100 percent increase from 1980–1982. At the same time, the average Medicare per visit payment rose by only 27 percent between 1978–1982 ($32.40/visit in 1978 to $41.37/visit in 1982) and only by 22 percent between 1980–1982 ($33.90 to $41.37).

Much of this limited increase in reimbursement outlays is due to general economic and demographic factors. Evidence of the impact of these factors in causing the limited growth in the Medicare home health benefit outlays appeared in an unpublished 1983 report prepared by Brandeis University and submitted to HCFA. The report, prepared under a HCFA contract in response to a Congressional mandate, is entitled "Alternative Methods of Reimbursement for Home Health Services under Federal Programs."

This report indicates that the major factors accounting for the rise in total Medicare reimbursements for home health visits between 1974–1980 were:

Factor	*Percent contribution*
Growth of the Medicare enrollment	9.9
Increase in the proportion of Medicare enrollees receiving home health visits	47.5
Increased visits per person served	7.7
Increased average cost per visit	84.9
Total	100.0

Since the focus of this report concerns methods of paying for home health services, a further analysis was carried out to explore the sources of increase in the average cost per visit. Factors contributing to the rise in the average cost per visit were:

Factor	*Percent contribution*
General economy-wide inflation	80.9
Inflation in the home health agency (HHA) market-basket in excess of general inflation	14.9
Cost increase per visit not explained in inflation (residual)	4.2
Total	100.0

The real reasons for home health growth are not the Omnibus Reconciliation Act of 1980 changes cited by the Secretary. The real factors are: general inflation, growth in the number of elderly, growth in the number of home health agencies and access to care, growth in new technologies which allow many types of medical care to be given at home which previously were inpatient hospital treatments, such as kidney dialysis, enteral and parenteral nutrition therapy, antibiotic therapy, and chemotherapy; and increased need for post-hospital care due to the DRG system (see GAO Report PEHD 85–3).

And with all this growth, home health still accounts for about only 2 percent of the total Medicare budget and only about 1 percent of the total Medicaid budget. And, according to HCFA's own data, only about 6 percent of all Medicare enrollees use the Medicare home health benefit. Add to this a number of recent studies by the U.S. Bureau of the Census, National Center for Health Statistics, General Accounting Office, and Urban Institute on the large portion of our naiton's population in need of some form of home care and the Heritage Foundation calling on a need for expanded home care as a "cornerstone" of national health policy both for humanitarian and cost reasons.

I ask you—Does this evidence indicate an unbridled growth of the Medicare home health program caused by inappropriate utilization and the lack of cost conscious behavior which justifies copayments as a corrective measure?

We believe the answer is a resounding "No." We believe the evidence indicates that Congress' intent to make home health available on a more equal basis with institutional care has, in part, been met. Congress dropped the existing copayment requirement in 1972 and made the 1980 changes with the enunciated goal of making home care more available. These changes combined with economic and demographic factors and the increase in available medical technolgies for use at home have provided the reason for the limited growth of the limited Medicare home health benefit in the face of a Medicare system that continues to emphasize hospital and nursing home care as a first option.

3. Lack of a true and equal choice between home health and institutional care utilization

Now, let us for a moment assume that Secretary Huckler's thesis is correct—that is, that there has been "a substantial increase in the use of home health services" due to a lack of sufficient "cost conscious behavior by beneficiaries".

We have heard some people say there should be a copayment requirement for Medicare home health care because there are similar requirements for other types of Medicare-covered care. Let's examine this thesis.

The theory of having premiums, copayments and/or deductibles is based on the assumption that if the beneficiary has a financial stake in the payment system for his health care, that he will be prudent in the utilization of that health care. In Medicare, this would mean the beneficiary would not make unnecessary trips to the hospital, would not undergo unnecessary surgery, would not incur unnecessary lengths of stay, and would not otherwise engage in non-cost conscious behavior. We believe the widom of this theory can be challenged as indicated by numerous studies indicating excessive lengths of stays, readmissions, and surgery and other procedures under the cost-based reimbursement system for inpatient hospital services. In fact the inability of deductibles and copayments to limit excessive hospital utilization was one of the major reasons for Congress creating the new Medicare DRG system.

However, let us put this point aside for the time being and follow the theory. In the theory you have the beneficiary (i.e., consumer) applying a prudent buyer brake to health care utilization due to his financial investment. Likewise, there is no brake or limit on utilization imposed by Medicare. That is, there is no fixed limit on the number of times a person can enter or stay in a hospital or skilled nursing facility. Even under the new hospital DRG system, the beneficiary can enter as many times and for as long a period as the hospital will permit. The Administration's copayment proposal for home health does not apply the same aproach.

Under the Administration's proposal, the existing Medicare-imposed limits on home health utilization would reamin and the new copayment brake would be added. The current limits include that: the patient must be "homebound"; the care needed and rendered must be "intermittent" only; the care must be "medically reasonable and necessary"; and there must be a physician-certified plan of treatment. The "intermittent" limit, under the interpretation of HCFA and its intermediaries, means only 2–3 weeks of care and, thereafter, care only continues on an exceptional circumstance basis as determined by the intermediary. (See comparison chart on Medicare, Part A hospital, SNF, and home health limits on utilization).

These Medicare-imposed utilization limits, particularly "intermittent care", have in effect limited home health utilization. Despite the enormous growth in the elderly and disabled population, the number and availability of home health agencies, and new technologies available for care at home, HCFA's own 1982 data shows the average Medicare home health beneficiary received only 26.3 visits a year and the 1984 HCFA estimates are about the same.

Our point is simple. The Medicare home health benefit already has an effective utilization brake in place in the form of the "intermittent" and other eligibility and coverage criteria. If the Administration feels home health should be made equal with hospitals and nursing homes in terms of having a copayment requirement, then home health also should be made equal with hospitals and nursing homes in terms of having no Medicare-imposed limits on utilization. This would make an equal choice of health care services available to consumers so they could choose in the free market place between hospital, nursing home, home health, physician, clinic, or other care. This would mean consideration of removing or clarifying the intermittent care definition (as proposed in S. 778), and even perhaps broadening the scope of available Medicare-covered services to include respite care, respiratory care, registered dietician care, adult day care, and homemaker services.

To impose copayments of any kind on beneficiaries for use of home health without lifting existing utilization limits would be contrary to the free market theory underlying the copayment proposal, discourage beneficiaries from using home health compared to institutional care, and unfairly place home health agencies at a competitive disadvantage compared to other Medicare-covered providers. We ask only that we be treated equally in the open market. We provide a good service at a quality level and are willing to take our chances in an open market which treats all providers equally.

It also would go contrary to Congress' original intent (as expressed in the Social Security Amendments in 1972) to encourage people to have access to and utilize home health care.

Let me close by saying that we have had an increasingly positive working relationship with the Health Care Financing Administration and their fiscal intermediaries. We share a mutual concern to streamline the home care delivery system while ensuring the delivery of quality care to fulfill the unmet needs of millions of Americans. We always have and will continue to have differences of opinions as to what constitutes covered and non-covered services. That is inherent in the nature of the statutory and regulatory language of the Medicare home health benefit which is laden with subjective, vague and unclear language. We will continue our efforts to amicably resolve these differences and to make the system more effective.

I thank you for this opportunity to testify and will gladly respond to any questions you may have.

MEDICARE - PART A

1984 LIMITS ON UTILIZATION OF PROVIDER SERVICES

TYPE OF PROVIDER SERVICE

	INPATIENT HOSPITAL			SKILLED NURSING FACILITY	HOME HEALTH AGENCY	
	FIRST 60 DAYS	61ST THRU 90TH DAY	60 LIFETIME RESERVE DAYS (NON RENEWABLE)	21ST THRU 100TH DAY	CURRENT	PROPOSED
LIMITS ON UTILIZATION	$356 DEDUCTIBLE	$89 COINSURANCE PER DAY^1	$178 COINSURANCE PER DAY^2	$44.50 COINSURANCE PER DAY^3	. NO DEDUCTIBLE	. $4.80/VISIT AFTER THE 20TH VISIT IN A CALENDAR YEAR
					. NO COINSURANCE	
	.ACCEPTANCE BY A HOSPITAL			.ACCEPTANCE BY A SNF	. "INTERMITTENT" 2-3 WEEK LIMIT: DAILY COVERAGE VARIES	. "INTERMITTENT" 2-3 WEEK LIMIT; DAILY COVERAGE VARIES
					. "HOMEBOUND"	. "HOMEBOUND"
					. "MEDICALLY REASONABLE & NECESSARY"	. "MEDICALLY REASONABLE & NECESSARY"
					. PHYSICIAN CERTIFICATION	. PHYSICIAN CERTIFICATION

Notes:
(1) Always equal to 25 percent of inpatient hospital deductible
(2) Always equal to 50 percent of inpatient hospital deductible
(3) Always equal to 12.5 percent of inpatient hospital deductible
(4) Part A premium is $155 as of January 1984

April 1985
National Association
for Home Care

Mr. Jacobs. Thank you.

Mr. Gradison.

Mr. Gradison. I would like to inquire further about the matter of copayments. I remember speaking with a representative of some of the neighborhood health centers which serve the inner city corridor in my largest community, Cincinnati, where they were planning to require a dollar or two payment for people who came to the door. And I was sort of apprehensive about the effect of this.

Conversation suggested it works out just fine. And if somebody absolutely cannot pay it, they still get the care. And most people value higher the benefits which they are getting by having paid a modest sum towards them. And that is not some think tank saying it, these are the people working in the health center who are telling me that.

I wonder, therefore, first what your reaction is to that comment; and second, how would you feel if instead of charging $4.80 for after the 20th visit we had a lower figure, a dollar or two that we charge starting with the first visit?

Ms. Cushman. I would like to respond to your question from two different perspectives.

One would hope that such a contribution would not limit the participation in the system. In home care—and I would be happy to supply for the record the figures—there have been situations that demonstrate the reverse trend, and also demonstrate some of the expenses in the copayment requirement.

The $4.80 versus $1 or $2 is I think not as big an issue as the expense associated with the Medicare requirement, how we must demonstrate the attempt to collect that. If a beneficiary does not pay we must demonstrate good faith by billing three times to collect that money.

It is that process which is more expensive. The $4.80 a visit, if people are unable to pay it, will be charged to Medicare as a bad debt. So it is the expense of the process that decreases the savings.

Mr. Gradison. Well, I understand that with regard to the administrative burden that may be an insurmountable problem. And in your earlier comments you mentioned it, but you seemed to focus on the concern that people would not get the care they need. And that is really the question I am asking.

Any evidence you can give us on this Medicaid experience as you refer to it, I would appreciate your just submitting it later because I would like to take a look at it. And I appreciate that it is easier to collect the dollar or two at the front desk in a fixed base setting of a neighborhood health center than it is out at somebody's home. I appreciate that.

Ms. Cushman. In terms of beneficiaries not receiving care, we do have a great concern with the limitations being placed on home care for other reasons, such as the definition of intermittent care. We are seeing clients increasingly being afraid to seek the care they need or to continue with it.

This is particularly frightening with the increase in the gap between institutionalization and home care, where home care coverage will begin where institutional care stops. We do see the potential of an increasing number of people going back into the hospital because of the increase in sicker patients being released from hospitals more quickly, coupled with these restrictions on home care.

Mr. **GRADISON.** I have no more questions.

Chairman **STARK.** I believe that concludes the hearing.

[Whereupon, at 11:35 a.m., the hearing was adjourned.]

[Submissions for the record follow:]

ALTERNACARE CORP.,
Los Angeles, CA, May 9, 1985.

Hon. FORTNEY H. STARK,
Chairman, Subcommittee on Health, Committee on Ways and Means, Longworth House Office Building, Washington, DC.

DEAR CONGRESSMAN: I read your March 27, 1985, news release regarding your hearings on 1986 Medicare budget issues. I was interested in the issues you are raising and feel we have two appropriate issues to bring to your attention. These issues have significant dollars associated with them. I am enclosing a recent letter which I sent to Dr. William Roper which outlines those issues along with pertinent attachments.

AlternaCare is a California based company that operates freestanding ambulatory surgical centers throughout the United States. All of our facilities participate in the Medicare Outpatient Program, as referred to in the attachments. We also accept Medicaid and any other patients regardless of their ability to pay. We perform a vital public service of the communities which we serve. Significant dollars are saved by Medicare beneficiaries when utilizing our facilities. We feel we have two legitimate problems needing correction. The first is the one described in the letter to Dr. Roper. The costly and discriminatory reimbursement differences between hospitals and freestanding are expensive to the Medicare program and provide disincentives for lower cost providers. The second is a restructured list of procedures that may be performed on Medicare patients. The Medicare program is needlessly spending additional dollars where there is a lower cost alternative for the same high quality of care Americans have come to expect from their medical system. In addition to the discrimination situation regarding reimbursement, Medicare relations have strictly limited procedures that can be performed in an outpatient surgery center. It is a shame these services cannot be broadened to serve more Americans who are Medicare age. There is very strong concurrence by physicians throughout the United States that more surgeries can be done on Medicare patients in an ambulatory surgical setting. I did not embellish this point in the attached documentation because I felt that it would be more appropriate to address the most pressing issue. However, your committee would be an appropriate forum to discuss this in greater detail. I would be happy to personally respond or have any of our physicians respond to inquiries by you or your counsel on these particular issues.

Sincerely yours,

ROBERT J. ZASA,
Vice President/Chief Operating Officer.

Attachments.

ALTERNACARE CORP.,
Los Angeles, CA, May 1, 1985.

WILLIAM ROPER, M.D.,
Special Assistant to the President For Health Policy, Old Executive Office Building, Washington, DC.

DEAR BILL: I appreciated your attention to my call, particularly regarding the issue of Medicare reimbursement surrounding outpatient surgery. I will attempt to describe and illustrate the issues clearly.

The Federal Register, dated Thursday, August 5, 1982, Part II, outlined the Medicare program relating to "Ambulatory Surgical Services and List of Covered Surgical Procedures." The regulations described reimbursement for both ambulatory surgical centers (ASC's) and incentive reimbursement for surgeons using outpatient surgery. I am attaching a copy of the pertinent pages of this document. In March, 1983, HHS published transmittal 964, Medicare Carriers Manual-Claims Process. Both documents are consistent with one another and until recently, I thought, clearly defined the payment process. In practice, I am finding inconsistency and some confusion as to how these regulations are applied by Medicare carriers in different states. The issues are as follows:

1. *Definition of an ASC.*—This seems to be the heart of the issue. As the regulatory are stated on page 34085, a hospital affiliated ambulatory care center can be

deemed an ASC. I totally agree that hospitals shold be able to participate; however, the regulations state the facility must be "a separate identifiable entity, physically, administratively, and financially independent and distinct from other operations of the hospital. Under this restriction, hospital outpatient departments providing ambulatory surgery (among other services) would not be eligible."

However, later under Physician Reimbursement (page 34089) the 100% physician incentive reimbursement is extended to "a hospital outpatient department" in addition to the previously defined hospital-affiliated centers and ASC's. The regulations go through great lengths to define the type facility able to participate in the program. Does the hospital outpatient department have to meet the previously defined criteria for ASC's to have the physician incentive reimbursement? According to the definition of an ASC, hospitals performing outpatient surgery in their main operating rooms, even those having a separate admit and discharge area, are not eligible to participate in the physician incentive reimbursement promulgated herein for ASC's. In Florida and Missouri, the Medicare carriers clearly are paying surgeons 100% for using hospital outpatient programs that do not meet the program participation and separate entity criteria. This position was even recently published in Medical Economics for Surgeons, April 1985 issue. If this is true, it seems to defeat the whole purpose of providing incentives to use lower cost alternative delivery systems (a participatory hospital center or ASC).

What makes the carriers' position additionally disappointing is the second issue:

2. *Facility Reimbursement.*—The hospital outpatient surgery facility's fee can be three times that of the free-standing ASC for Medicare approved procedures. The average hospital charges $1,500 for a cataract extraction with lens implant (excluding the lens) versus actual reimbursement to an ASC ranging from $500-$550 (depending on geographic location). Across the board hospital fees are 20-40% higher than an ASC's. Why would physician incentive reimbursement be promulgated for facilities which bill and get reimbursed a significantly higher fee? I feel this intent of the regulations was to allow an appropriate, hospital-affiliated facility to participate in the MD incentive reimbursement program and compete on an even basis with an ASC in its area, *if* they agreed to "participate in this program as an ASC" (page 34085 of the August 5, 1982 federal register). The paragraph goes on to say that "it (the hospital) will not have the option to change to participation as a component of the hospital. In other words, it must participate and be reimbursed as an ASC unless HCFA determines there is good cause to do otherwise."

Bill, it seems there is a clear discrepancy between the way the regulations are written and the way they are being implemented. We don't mind competing and HCFA made these rules to encourage lower fees billed to Medicare (facility fees) by providing the physicians an incentive, but ASC's should either be able to bill Medicare the same as the hospitals do and obtain the 100% surgeon reimbursement or the rules should be enforced not to give surgeons incentives to use facilities that do not come under the same DRG fees as ASC's.

There are a significant number of ASC's throughout the United States to assure access to the population. The regulations properly allow hospitals to participate like an ASC when providing services to an area. I want clarification on what HCFA's real intent is before I go back to the carriers. I would like to know if the Medical Economics article is correct.

In light of the total dollars spent on healthcare, this issue is a growing one. Currently, approximately 20% of all surgery is done on an outpatient basis and in the eleven cities where AlternaCare has facilities, this percentage has risen significantly. The dollars related to this issue are growing. I would appreciate your help in gaining a clear understanding of the official, federal position on ambulatory surgical reimbursement.

Sincerely,

ROBERT J. ZASA,
Vice President/Chief Operating Officer.

[From JAMA, Jan. 18, 1985]

LETTERS TO THE EDITOR

AMBULATORY SURGICAL CENTERS

TO THE EDITOR.—Today everyone is interested in containing the high price of medical care. Many innovative approaches have been initated by health care professionals to help reduce medical costs. One of these approaches has been the development of ambulatory surgical centers across the United States. It has been well documented that ambulatory surgical center charges can save as much as 30% to 50% on the cost when compared with charges incurred when surgery is performed on an outpatient basis in a hospital setting. A substantial portion of all these surgical procedures are performed on elderly patients (aged 65 years or older, or recipients of Medicare).

If a cataract extraction is performed at an ambulatory surgical center, the federal government has dictated that a maximum reimbursement of $329 be made. This outpatient fee is all-inclusive. If this same procedure is performed on an outpatient basis at a hospital, the charges are on a cost-plus basis, which is to say that all supplies and anticipated overhead costs are added in to the charge of Medicare. These charges amount to about $1,100 to $1,600.

The total average cost that an ambulatory surgical center such as ours incurs for this particular procedure is about $526. As one can see by these figures, there is at least a $500 to $600 savings incurred for the same procedure done in the same way if performed in an ambulatory surgical center.

Information made available to me by the American Intraocular Implant Society, which is responsible for intraocular lenses following cataract operations, indicates that as many as 600,000 to 750,000 cataract operations are performed annually in the United States. If you take an average cost of $1,200 and multiply it by 600,000, you come up with a cost to the federal government of $780 million on cataract operations alone. If these operations were done at ambulatory surgical centers, the cost would be reduced by roughly 50% and a savings to Medicare of $390 million would result. There are approximately 100 surgical procedures that have been approved by Medicare to be done in ambulatory surgical centers. Conservatively, I would estimate that there would be a savings of between $1.5 and $3 billion a year if these facilities were utilized to their maximum potential.

It seems that if the Medicare people were interested in cost containment, they would (1) establish a reasonable fee for procedures that would be the same for ambulatory surgical centers and hospital-based outpatient surgical facilities and (2) encourage the private sector to continue to search for more cost-effective approaches to medical care by supporting these efforts with a reimbursement rate that would allow ambulatory surgical centers to remain in business.

If some sort of cost adjustment is not forthcoming soon, the ambulatory surgical centers are not going to be able to afford to provide this reduced medical care cost to Medicare patients. When this point is reached, the general population is once again going to be hit with higher medical costs than are necessary because they will once again be placed in a hospital setting that has been documented to be more expensive to all patients.

STEPHEN V. STEPHENSON, M.D.,
Bryan-College Station, Ambulatory Surgical Center, Bryan, TX.

[From Medical Economics for Surgeons, April 1985]

PROFESSIONAL BRIEFS

CHEAP IS NICE, BUT AVAILABILITY IS ESSENTIAL

Apparently concluding that the availability of health care is more crucial than price, the American Association of Retired Persons has done a 180-degree turn on the Medicare fee freeze. Originally a supporter of the 15-month freeze on payments to doctors, AARP now opposes its extension. The group fears a longer freeze might provoke doctors to drop out of the system.

WHERE ONE PRO IS FUELING A PRICE WAR

Ambulatory surgery in Florida is growing more profitable, thanks to new peer review rules requiring that most cataract surgery for Medicare beneficiaries be performed on an outpatient basis. Surgeons, especially, have an incentive to comply: Medicare will pay a surgeon 100 percent of his allowable fee (about $1,000 in south Florida) if he does the procedure on an outpatient basis—whether at a certified ambulatory surgicenter or a hospital operating room. Meanwhile hospitals are attempting to protect their bottom lines by mounting campaigns to increase OR utilization: Some hospitals, as well as doctors, are accepting patients' insurance as payment in full.

TREATMENT DECISIONS SHOULD BE A SHARED RESPONSIBILITY

Four Americans in five want their doctor to advise them on ways to prevent illness or improve health, according to a survey by Louis Harris and Associates Inc. But when it comes to deciding the course of treatment, most patients say it should be a joint decision. A vast majority, for example, want their doctor to consult with them and give them options before making surgery, diet, and exercise recommendations. On the other hand, two in five want the physician alone to decide medication regimens.

DRG: WHAT DO YOU CUT AFTER YOU'VE CUT OUT THE FAT

The majority of hospital administrators expect to profit under Medicare DRG, a recent survey shows, but those profits may be slim at best. In New Jersey, the birthplace of DRG, the entire $3 billion hospital industry showed a paltry $3 million profit in 1983—hardly more than break-even, but its first taste of any profit since DRG began there five years ago. Moreover, since only 32 hospitals reported operating losses, most profitable ones were just barely in the black.

federal register

Thursday
August 5, 1982

Part II

Department of Health and Human Services

Health Care Financing Administration

Medicare Program; Ambulatory Surgical Services and List of Covered Surgical Procedures

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Care Financing Administration

42 CFR Parts 405 and 416

Medicare Program; Ambulatory Surgical Services

AGENCY: Health Care Financing Administration (HCFA), HHS.

ACTION: Final rule.

SUMMARY: These regulations implement in part, section 934 of Pub. L. 96-499, the Omnibus Reconciliation Act of 1980, which adds to the benefits available under Part B of Medicare, facility services associated with certain surgical procedures provided in an ambulatory surgical center. That section also provides, under certain conditions, for 100 percent Medicare reimbursement to physicians (rather than the usual 80 percent) for services provided in connection with certain surgical procedures performed on an ambulatory basis. These regulations establish (1) The standards an ambulatory surgical center must meet to be approved for participation in the Medicare program; (2) criteria for determining which surgical procedures will be included for purposes of reimbursing facilities and physicians under this provision; (3) the payment methodology and reimbursement procedures with respect to facility services; and (4) the requirements relating to agreements by the facility to furnish services under the program and by physicians with respect to accepting payments for procedures (agreements to accept "assignments").

The purpose of the legislation and these regulations is to encourage the performance in an ambulatory setting of certain surgical procedures that are now frequently furnished on an inpatient hospital basis. The regulations assure that these procedures are only those that are appropriately and safely performed in an ambulatory setting, and that the cost to the Medicare program of services provided in that setting is lower than would have been incurred for services provided on an inpatient basis.

EFFECTIVE DATE: These regulations are effective September 7, 1982.

Section 416.30(c) of these regulations contains reporting requirements and §§ 416.43 and 416.47(b) contain recordkeeping requirements which have not yet been approved by the Executive Office of Management and Budget (EOMB) but are subject to the Paperwork Reduction Act (Pub. L. 96-511). Since the information required to be reported under § 416.30(d) will be used to evaluate the payment methodology and update payment rates, this information will not be gathered until centers have obtained some experience with the program.

The reporting and recordkeeping requirements in these sections are not required until EOMB approval has been obtained. HCFA will publish a notice in the Federal Register when approval has been obtained, indicating the effective dates of these requirements.

FOR FURTHER INFORMATION CONTACT:

Sheila Ryan (Covered Procedures), 301-594-3561
Bernard Truffer (Reimbursement), 301-597-1369
Margaret Van Amringe (Health Safety and Other Facility Standards), 301-594-9712
Harold Fishman (Assignment Agreements), 301-594-9077

SUPPLEMENTARY INFORMATION:

I. Background

Generally, there are two elements in the total charge for a surgical procedure—a charge for the facility services (such as use of an operating room) and a charge for the physicians' professional services for performing the procedure.

A. Facility Services.—Currently, facility services for surgical procedures performed on a hospital inpatient basis are reimbursed under Medicare Part A at 100 percent of the facility's reasonable costs. For facility services associated with ambulatory surgery, coverage and reimbursement are available only in a hospital-related ambulatory surgical setting; that is, on an outpatient basis in a hospital or in a hospital-affiliated ambulatory surgical center (HAASC). These ambulatory surgical facility services are reimbursed under Part B of Medicare at 80 percent of the reasonable cost. The Medicare beneficiary is responsible for any unmet portion of the Part B deductible and for the coinsurance for the procedure.

Medicare law has not previously permitted coverage or payment for overhead expenses of surgery performed in a physician's office, nor for facility services in an independent ambulatory surgical center (ASC); that is, an ASC not related to a hospital. Thus, costs, such as for nurses and operating room technicians, have not been reimbursable in an ASC or physician's office settings.

B. Physician's Professional Services. Currently, Medicare reimbursement for the physician's charge for performing a surgical procedure is made at 80 percent of the reasonable charge for the service, without regard to the setting (inpatient hospital, hospital-related ambulatory surgical setting, ASC or physician's office). The beneficiary is responsible for the Part B deductible and coinsurance amounts for physician's services in all settings.

II. Legislation

Section 934 of Pub. L. 96-499, the Omnibus Reconciliation Act of 1980, amended sections 1832(a)(2), 1833, 1863 and 1864 of the Social Security Act (Act) to permit broader coverage of ambulatory surgery under Medicare. In summary, the legislation—

- Extends Medicare coverage to facility costs or overhead amounts for certain surgical procedures furnished in an ASC or a physician's office and directs the Secretary to establish the payment for those services.
- Eliminates deductible and coinsurance amounts for ASC facility services costs for certain surgical procedures performed on an ambulatory basis. It also eliminates these amounts for physicians' professional fees in connection with surgery performed in an ambulatory surgical setting when the physician agrees to accept assignment.
- Directs the Secretary, in consultation with the National Professional Standards Review Council and appropriate national medical organizations, to specify the surgical procedures that would be covered under this provision.
- Specifies that the Secretary develop standards which an ASC must meet to participate in the Medicare program.
- Requires the Secretary to use services of the State health agency or other appropriate State or local agencies to determine an ASC's compliance with the standards established.

III. Proposed Rules

On March 23, 1982, we issued a notice of proposed rulemaking (47 FR 12574) and a proposed notice containing the first proposed list of procedures (47 FR 12591) that would implement in part the changes made by section 934. (The portion of the law concerning physicians' offices was not addressed.) The provisions discussed in the preamble to the proposed rule dealt with four major areas: ASC health, safety, and other standards; coverage of procedures; reimbursement; and acceptance of assignment.

A. ASC Standards

Section 1832(a)(2)(F)(i) of the Act requires the Secretary to establish health, safety, and other standards that ASCs must meet to enter into an agreement for participation in Medicare. The proposed rule set forth standards

A. ASC Standards

Only 38 respondents commented on issues related to health and safety. There were two major concerns. The first regards how an eligible ASC should be defined. The second is whether ASCs accredited by national accrediting bodies or licensed by State agencies should be deemed to meet the conditions for coverage (§§ 416.40 through 416.49).

1. *Definition of an ASC.* The issue raised by commentors concerning the definition of an ASC had two aspects. The first is whether an HAASC should have the option to participate in the ASC program. Our proposed rule excluded HAASCs from participation for two reasons.

- HAASCs are already eligible to participate in the Medicare program as part of a hospital.
- We believed that HAASCs would prefer to continue to be reimbursed on the basis of reasonable costs for all surgical procedures performed.

The comments received, however, lead us to believe that some HAASCs would prefer to participate in Medicare in the same manner as independent ASCs. In response to these comments, and because section 934 does not explicitly exclude HAASCs from participating, we are revising the definition of an ASC contained in our regulations § 416.2 to allow HAASCs the option of participating in this program. For purposes of clarification we will refer (in this preamble and § 416.30) to those HAASCs that elect this option as "ASCs operated by a hospital". For purposes of the remainder of these regulations, the term "ASC" includes ASCs operated by a hospital. The following restrictions, however, must be observed.

- Once the ASC operated by a hospital elects to participate in this program as an ASC, it will not have the option to change to participation as a component of the hospital. In other words, it must participate and be reimbursed as an ASC unless HCFA determines there is good cause to do otherwise.
- The ASC operated by a hospital must be a separately identifiable entity, physically, administratively, and financially independent and distinct from other operations of the hospital. Under this restriction, hospital outpatient departments providing ambulatory surgery (among other services) would not be eligible. (§ 416.2)
- The ASC operated by a hospital must meet all requirements (i.e., health and safety, coverage, reimbursement, and assignment) applicable to independent ASCs.

The second aspect of the ASC definition that generated comments is the degree to which an ASC is distinguished from a private physician's office. Section 934 of Pub. L. 96-499 distinguished between ambulatory surgical centers and private office practices, both in terms of health and safety standards that must be met, and in terms of surgical procedures that are appropriate in each setting.

Because it is not feasible to describe in any reasonable detail what constitutes an ASC, as opposed to other entities providing health services, we have decided to adopt the general definition as stated in § 416.2. This, we believe, will not result in problems for the following reasons:

- The requirement that an ASC must operate "exclusively" for the purpose of providing ambulatory surgical services, will exclude private office practices that provide other health services.
- While State licensure and Certificate-of-Need (CON) requirements vary a great deal from State-to-State, we believe that they will exclude many private office practices from eligibility as ASCs.

These regulations do not address physicians' offices. As we indicated in our March 25, 1982 proposed rule, there were several considerations in this regard. The most compelling that precludes immediate implementation, is that coverage under the Medicare statute of overhead costs associated with surgical procedures performed in the physician's office setting is contingent upon, among other things, review of the performance of those procedures by a Professional Standards Review Organization (PSRO). PSROs are not now engaged in this type of review. We are continuing to evaluate this area with a view towards implementing this provision as soon as is feasible.

2. *Deemed Status.* Of the comments received on our deemed status proposal, most commentors favored some type of deemed status, but were divided on what basis deemed status should be granted. The industry tended to support recognizing, as a basis for granting deemed status, accreditation by a national accrediting organization as opposed to State licensure. In contrast, most States that responded had the opposite viewpoint. Few respondents were for deemed status unconditionally. Further, some commentors suggested that we acquire more experience with ASC certification, ASC accreditation, and State licensure programs before we grant deemed status.

We have already received three formal requests from organizations concerning deemed status. These were from the AAAHC, the Joint Commission on Accreditation of Hospitals, and the American Osteopathic Association. In addition, at least twenty-two States have licensure programs and may potentially apply for ASC deemed status with regard to their programs.

We believe that granting deemed status on the basis of accrediting or licensure programs which are equivalent to Medicare requirements is in the best interest of the Medicare program, the provider community, and the health care system. However, the divided nature of the comments and the number of entities already requesting, and expected to request, recognition with regard to deemed status dictate that we move judiciously in this area. While we support deemed status as important to reducing duplication in terms of program enforcement activities, our paramount responsibility is the protection of beneficiary health and safety.

We are still in the process of assessing existing ASC accrediting and State licensure processes. At the time we published the proposed rule, we had only reviewed the health and safety standards of the AAAHC, and the written requirements of a number of State licensure programs (many of which have been recently updated). Since publication of the proposed rule, we have not received all, nor fully examined, materials on the actual survey processes, surveyor qualifications, accreditation and licensure decision-making processes, or monitoring procedures of the various deemed status candidates to come to a decision now on specifying which organization's or State's program would be acceptable for purposes of deemed status. As we complete a comprehensive review of each candidate's program, we will publish in the Federal Register the names of those organizations or State programs approved for deemed status purposes.

We feel that the need to make the ASC program available as quickly as possible takes precedence over waiting for completion of our individual deemed status examinations. This additional time to finish our reviews will provide us with valuable information from the first round of certifications.

Therefore we are not granting deemed status to ASCs on the basis of accreditation by any specific organizations or licensure by a State until the above concerns are resolved. We are revising § 416.29 to establish, in regulations, the authority to grant will publish proposed changes for public comment.

6. *Return on Equity Capital.* Two ASCs and an ambulatory surgery association suggested that the payments made to ASCs be adjusted to permit a specific return on equity capital. We have not accepted the comment.

The methodology for payment of facility services in ASCs is a prospective rate system, in which a standard rate is paid for a surgical procedure without regard to the costs of a particular facility. If a facility's cost of providing a particular service is less than the rate for that procedure, the excess is retained by the facility. While the rates for ASC reimbursement were based on the costs and charges of ASCs, an allowance for equity capital return was not included in these costs because it would diminish the incentive for efficient operation in the prospective system. An explicit recognition of return on equity capital is appropriate only for cost-based payment systems which do not otherwise recognize an opportunity for profit or loss with respect to covered services furnished to Medicare beneficiaries.

7. *Adequacy of Group Rates.* A number of comments were received which addressed the level of rates in general, or the rates for particular procedures. Eight ASCs and an ambulatory surgery association suggested that all the rates should be increased, in that the rates were felt to be unrealistically low and would discourage treatment of Medicare patients. One of these commentors suggested that the rates be increased by 10 percent, while others did not specify the level by which rates should be increased.

We disagree with the suggestion that the rates are inadequate. For ASC facility services, the statute requires payment of a standard overhead amount based on the Secretary's estimate of a fair fee that is relative to the cost of furnishing the service generally and is substantially less than the fee that would be paid if the procedure were performed on an inpatient hospital basis.

Again, in order to obtain current data on ASC facility costs and charges, we asked FASA to assist us in conducting a survey of its members. The group rates specified in the proposed rule are based on actual cost and charge information as reported by the facilities, updated for inflation. Based on the data, the average ASC will be reimbursed 90 percent of its charges for covered procedures furnished to Medicare patients. We have estimated, using the facility cost data, that this level of payment will result in ASCs recovering their cost, which conforms with the intent of the statute.

Nine comments, from ASCs, hospitals and physicians addressed the adequacy of the rates for specific procedures, particularly for cataract extraction and arthroscopy. One commenter suggested that the rate for an iridectomy was excessive.

Our data indicate that the average cost-adjusted charges for extraction of cataracts and for iridectomy are somewhat below the group 4 rate of $338, while the average cost-adjusted charge for arthroscopy is somewhat above that rate. The payment system for ASC facility services is designed to reimburse all procedures in a group at a standard rate. Implicit in such a system is the expectation that some particular procedures in the group may be reimbursed at less than cost, while other procedures may be paid for at a rate higher than cost. There is no intent that a particular facility will be paid at a rate exactly equal to its costs for each procedure that it provides. Rather, the intent is that, in the aggregate, the average ASC will be paid the costs that it incurs in providing facility services.

As we obtain more data on ASC costs and charges, and after we have more experience with the payment method, we intend to work to refine the payment groups and levels to make the rates more procedure-specific.

8. *Exception to the Rate Structure.* Several comments were received which requested various types of exceptions to the rate structure. One commentor suggested that the rates should be adjusted for new facilities to reflect the high cost of initial capital outlays for new ASCs, to encourage new facilities to develop. We disagree with this comment. We believe our rate structure should be neutral to the question of entry of new facilities into the market, and that the rates should neither encourage nor discourage new entrants. To provide a special allowance for new facilities would be to provide, in effect, a subsidy which might encourage the development of excess surgical capacity.

Another commentor stated that the rates do not account for rural and other ASCs with low-volume, and suggested that an exception be provided for these facilities. While few rural facilities were included in our data base, we see no evidence that these facilities will be disadvantaged by the rate structure. With respect to an exception for low-volume facilities, although section 1833(i)(2)(A)(i) of the Act and the report of the Senate Committee on Finance (Senate Rep. No. 96-471, 96th Congress, 1st session, 35 (1980)) accompanying the ambulatory surgery legislation permits the Secretary to consider volume in establishing payment rates for ASCs, we have not implemented such an adjustment. At present our data do not permit us to make such an adjustment. However, we intend to monitor closely the impact of our payment structure on ASCs, by examining claims and cost data from sample facilities. We will consider the future reviews of the payment rates, the effect of our payment system on ASCs providing either low or high volumes of services to determine whether adjustments are warranted.

Another commentor suggested that ASCs be permitted to bill patients for supplies, operating room time and staff costs associated with a particular procedure which takes more than the standard time allotted for the procedure. This comment is rejected because it is not permitted by the statute, which requires that the ASC, in order to participate, must accept the rate determined by the Secretary as payment in full for the procedure. Billing to the Medicare beneficiary for any facility service is not permitted.

9. *Physician Reimbursement.* The proposed regulations provided that a physician performing a covered surgical procedure in a hospital outpatient department, hospital-affiliated ambulatory surgical center or an ASC would be reimbursed at 100 percent of the reasonable charge for the service if assignment was accepted. One comment was received from a prepayment plan that the proposed regulations did not address situations in which physicians' services are reimbursed on a reasonable cost basis, rather than on a reasonable charge basis. The commentor suggested that, in these situations, physicians' services be paid for at 100 percent of the reasonable cost, to coincide with the provisions for reasonable charge payments. We agree, and have modified §§ 405.240(a) and 416.120 of the regulations to permit health maintenance organizations reimbursed under section 1876 of the Act to be reimbursed at 100 percent of the reasonable cost for the services of physicians related to the performance of certain surgical procedures in appropriate ambulatory surgical settings. We will modify the cost reporting system and instructions for these plans to make the necessary adjustments.

We considered extending a similar provision to group practice prepayment plans (GPPPs) which, under section 1833(a)(1)(A) of the Act, may elect to be reimbursed on a reasonable cost basis, for covered medical and other health

STATEMENT OF THE AMERICAN ACADEMY OF FAMILY PHYSICIANS

The American Academy of Family Physicians is taking this opportunity to submit comments on the Medicare Budget issues being studied by this subcommittee. We appreciate the concern of the subcommittee members in considering the impact of the President's proposed budget for Fiscal Year 1986 on Medicare providers and beneficiaries. We are well aware of the difficult task before Congress this year in reducing an enormous federal deficit, but are encouraged by this subcommittee's efforts to consider the possible effects of these cuts.

As the Administration and Congress seek to reduce federal expenditures, again they look at the Medicare program for a large portion of the savings. Medicare has been and continues to be a natural target because of the sizable program expenditures. We wish to caution the subcommittee that for this reason, Medicare has also been a major factor in shaping America's health care delivery system, affecting the way medicine is practiced, how providers are reimbursed and who will practice medicine. As Congress looks at the various proposed ways to cut the budget, it is more imperative than ever that before federal funds are expended in such a way as to do the most good for the greatest number of people—that short term budget cuts do not take precedence over long term policy implications. The Medicare proposals in the proposed Administration and Senate budgets will have a significant impact on family physicians and their patients.

The AAFP is opposed to the freeze extension on physician Medicare reimbursement and fees proposed in both the Administration and Senate budgets. Last year Congress passed the Deficit Reduction Act of 1984 which included a freeze on physician's customary and prevailing charges for fifteen months at 1982 levels. The freeze was intended to reduce Medicare expenditures, while providing incentives for physicians to become "participating physicians" in the Medicare program. The major incentive was that participating physicians would be allowed to increase their billed charges, with the promise that at the end of the freeze, adjustments would be made in participating physicians' customary charges based on those increases in their billed charges during the freeze.

The American Academy of Family Physicians, along with the American Medical Association, wholeheartedly endorsed a one year voluntary freeze that ended in February 1985, which involved nearly 80% of all physicians and was estimated to have saved approximately $1.5 billion. Furthermore, the Academy continues to urge its membership to give special consideration to cases of financial hardship on a patient-by-patient basis. Physician's willingness to contribute to deficit reduction has been demonstrated.

The American Academy of Family Physicians believes, however, that a fee-freeze extension is contrary to sound national health policy and may reduce access to medical care for the elderly. As the cost of practicing medicine continues to escalate and reimbursement falls behind, we are concerned by the very real possibility that an increasing number of physicians may choose not to accept Medicare patients. Another unintended result may be increased cost of medical care for non-Medicare patients.

The fee freeze has different implications for different specialties, as well as different individuals within a specialty. Figures recently released by the Health Care Financing Administration indicate that 29.4% of all physicians participating in the Medicare program have signed agreements to become participating physicians. The participation rate for "general practitioners" is shown as 27.3% and the rate is 25.5% for family physicians compared, for example to 41.3% for radiologists, and 50.89% for neophrologists. What these figures don't show, but suggest, is that there is an inherent inequity in the current Medicare reimbursement system, which emphasizes costly, inpatient, procedurally-oriented care and which generally provides less reimbursement when provided by a general practitioner or a family physician than when the same service is provided by some other type of specialist.

Indeed data provided by the AMA Socioeconomic Monitoring service indicate that from 1982 to 1983 all physicians experienced an increase in net income of 6.8%, while family physicians/general practitioners experienced a decrease in net income of 4.7%. During that same time, medical specialties had an increase in net income of 4.8% and surgical specialties increased 9.6%. The data further reveal that the median income for all physicians in 1982 was $85,000 compared to a median income for general practitioners/family physicians of $63,000. In 1983 the median income for all physicians was $45,000, compared to $40,000 for general practitioners/ family physicians.

Congress initiated a study of the reimbursement problem in last year's Deficit Reduction Act. As a result, the Office of Technology Assessment is currently studying several issues surrounding Medicare payment to physicians, including the differential in Medicare payment for cognitive services as compared to procedural services. It is hoped that the finding of the OTA study will provide the impetus for a resolution in the inequities that exist between reimbursement levels for procedural versus cognitive services. Such changes in the Medicare payment system would make Medicare assignment more attractive for family physicians and also be beneficial in assisting family practice residency programs to generate a greater percentage of revenues from patient care income.

Extending the fee freeze, however, unfairly perpetuates the existing inequities in Medicare reimbursement. It penalizes those physicians whose reimbursement under Medicare was already inadequate before the freeze went into effect. The primary role of family physicians as patient advocates is being jeopardized by economic realities. And, as new graduates of medical schools look at this situation and the impact on their futures, less are choosing the specialty of family practice. This will have a detrimental effect on the nation's health care delivery system.

Reduction in the Medicare component of financing graduate medical education is also of major concern to the AAFP, because it affects the future of family practice training and the continued vitality of the profession. The AAFP notes that family practice residency programs fulfill an essential societal need by producing well qualified family physicians able to provide cost effective, comprehensive and continual care to all members of the family regardless of age, sex, medical problem or organ system involved. Data clearly shows that graduates of family practice residency programs are locating their practices in rural as well as urban underserved areas. Approximately 50% of family practice graduates enter practice in communities with populations of 25,000 or less and over half of these are located in areas not within 25 miles of a large city. This compares with approximately 11% of physicians in other specialties who enter practice in non-metropolitan areas. A survey in July 1983 shows that less than 2% of family practice residency graduates report that they plan to take further specialty training. Family practice residency graduates stay in family practice. We believe that the country continues to need well qualified family physicians who provide cost effective preventive care in an ambulatory setting. For the past decade, Congress has targeted family practice for financial support through Public Health Service grants in response to the nation's need. However, this support is targeted for termination in both in both the Administration and Senate budgets.

Therefore any reduction in the Medicare medical education payments poses an additional burden for these programs. As resources of teaching hospitals become more scarce, the potential for the elimination of family practice and other primary care training programs increases. While graduate medical education programs greatly enhance the quality of care in teaching hospitals, they add significant costs. Major reductions in the indirect medical education payments will force most teaching hospitals to reassess their commitments to graduate medical education. As hospitals reassess these commitments they can be expected to maintain those programs which generate the most revenue and to reduce or eliminate those programs which tend to be financial loss leaders. This will be particularly true for those hospitals which are being increasingly squeezed financially by the DRG system. Family medicine and other primary care programs will not fare well. These programs emphasize ambulatory services and cost containment and simply do not generate adequate income in the current reimbursement system to be financially attractive to teaching hospitals. Hospitals, facing budget constraints, will have few incentives to retain family practice and other primary care programs. In 1984, over a dozen hospitals indicated their decisions to eliminate their family practice residency programs. Financial uncertainties in funding graduate medical education have contributed in a major way to these decisions.

Last October, the American Academy of Family Physicians, concerned about potential cutbacks in federal funds for training programs in family medicine, mailed a brief questionnaire to 383 directors of family practice residency programs to garner some idea of the potential effect of withdrawal of federal funds. A total of 335, 87.5% of the program directors responded, with 50% indicating that their programs receive federal support (184 programs) either directly or indirectly through a medical school or other source. Among these programs receiving federal support, 59% of the program directors indicated that elimination of funds would cause a reduction in the number of faculty and support staff; 48% indicated that there would be a reduction in the elements of curriculum, and 24% indicated that a reduction in the number of residents would result. While this information is, by its nature, subjective, we believe it is indicative of the potentially serious impact of the withdrawal of federal funds from family practice training programs.

The combined effects of these major reductions in federal support for medical education without reform to take into account primary care programs may well result in a significant decrease in the number of programs—a result which is not consistent with sound health policy.

The AAFP believes that the proposed budget cuts in Medicare should be carefully evaluated and their effects on the quality of health care and continued access to providers considered. Medicare beneficiaries ultimately will bear the brunt of the cuts if quality and access cannot be ensured. Our nation's health care delivery system continues to be shaped by your decisions. Your consideration of these issues and our comments is appreciated.

Statement of the American Association of Colleges of Nursing

The American Association of Colleges of Nursing (AACN) represents 384 college and university schools of nursing and approximately 8,000 full-time faculty. Our organization exists to improve the practice of professional nursing through advancing the quality of baccalaureate and graduate programs, promoting research, and developing academic leaders.

The Medicare passthrough for Graduate Medical Education includes cost-based reimbursement for the education of physicians and other health care personnel including nurses. The amount of Medicare reimbursement for nursing education is uncertain, and studies to establish the cost of nursing education should accompany the establishment of rational policy regarding Medicare coverage of nursing education costs. The AACN is committed to studying the question of the cost of nursing education nationally, and has developed a policy for rational distribution of Medicare dollars for nursing education that is based upon the provision of service to patients by licensed, highly qualified students and faculty. The AACN policy is attached for your information.

Policy of the American Association of Colleges of Nursing on Medicare Reimbursement for Clinical Graduate Nursing Education—February 1985

INTRODUCTION

Medicare (Title 18) was established to assure the provision of health care services to the elderly. The majority of Medicare services are provided in hosptials, nursing homes an private and public home health agencies. Since Medicare reimburses health care providers for services given to recipients, the governemnt has a rightful interest in assuring that appropriately qualified health professionals provide service which is both of high quality and cost-effective. This interest has been recognized in the pass-through mechanism for hospitals where the bulk of care is provided. It is well known that nurses provide a large share of the professinal health care rendered to the elderly in our society, it must be assumed that nurses will continue to provide a large share of care to recipients. Physicians alone cannot meet this need. Currently, questions have been raised as to whether education of physicians, nurses and other health care professionals should continue to be subsidized by Medicare dollars and, if so, at what level of support. To ensure a continuing supply of qualified nurses to meet the health needs of Medicare recipients, in any redesign of Medicare regulations, serious consideration should be given to developing policy that will support nursing education in a more rational manner than in the past when only ad hoc approaches have prevailed.

POLICY

The AACN recommends that HCFA continue reimbursement for nursing education through Medicare dollars, at least at the current level which is reported in the 1983 IOM Study to be in the neighborhood of 350 million dollars. A rational plan for redistribution of the nursing education dollar means directing Medicare funds to clinical graduate nursing education, i.e., those programs in which a Registered Nurse is enrolled in a graduate degree granting program in nursing and provides clinical service to the elderly. Master's and doctoral programs in nursing are included within the category of clinical graduate nursing education. It is increasingly recognized that professional preparation for nursing is taking place in degree granting institutions, many of which have strong ties with university and community teaching hospitals.

Hospitals or educational programs should bill and be paid for service given the elderly by students and faculty and for the salaries and other costs associated with the supervision of clinical experiences of graduate nursing student. Those portions of clinical graduate nursing education programs that are carried out in hospitals and other clinical agencies that provide services to Medicare patients should be supported.

RATIONALE

The justification for requesting support of the clinical training which occurs in the graduate nursing programs is concerned with the fact that clinical teaching cannot occur in the absence of service to patients. The inclusion of practical patient care experiences is central to clinical graduate nursing education. Supervision is provided by faculty members who are experienced in the field, and students provide service to patients while obtaining an education. The students are fully licensed R.N.s who have decided to return to school to advance their professional education. Nursing students must pay tuition, but they receive no stipends for the service they provide patients. A limited amount of scholarship assistance is available from the government or voluntary agencies. Federal funds to support specialty education have decreased rapidly, particularly for Master's degree students. Since a high portion of Master's programs are designed to prepare clinical nurse specialists in various settings such as primary care and gerontology, it is reasonable and appropriate that Medicare dollars support these services. Patients benefit directly by the care given by graduate nursing students. The society as a whole also benefits form the maintenance of an adequate supply of providers and a high quality of education for nurses.

It is abundantly clear that nursing school faculty differ in significant ways from faculty in other health care professions. Nursing faculty have not been privileged to be included in fee for service arrangements. They have generally not been able to call upon graduate students to assist with the training of graduate students. The time and effort spent by nursing faculty who supervise students in clinical experiences should be viewed as making a significant contribution to service, but this has not been the case. In most cases, faculty salaries are paid in full by colleges and universities even though a significant percentage of their time and effort is devoted to service activities in hospitals. A similar policy has been in place for the training physicians for many years. However, the nursing community has benefitted only minimally for similar efforts directed at caring for the elderly. Nursing faculty time and effort spent in supervision of clinical graduate nursing education students and in the provision of direct service to patients should be reimbursed by Medicare.

The AACN policy recognizes that Medicare dollars for nursing education historically have been attached to hospital financing. The intent of AACN is to ensure continuance of the flow of these funds to hospitals, not only to improve in-hospital clinical services, but also as an attempt to free up financial resources that should be used for ambulatory and home health services provided by nurses. Financial support should be given by the public sector, the private sector, students, patients and third party payors. With multiple sources of funding available, access to high quality health care and health care education will be maintained. Nursing has recognzied the changing demographic and economic environments and has moved quickly to provide needed service to the elderly population. With adequate financing from Medicare, nursing education can continue this responsiveness to the needs of the elderly.

STATEMENT OF THE AMERICAN SOCIETY OF INTERNAL MEDICINE

INTRODUCTION

The American Society of Internal Medicine (ASIM) is a national medical society consisting of physicians who are recognized as specialists in internal medicine. ASIM members typically see a large proportion of Medicare patients in their practices. Consequently, ASIM has a particular interest in the effects of proposed cuts in the Medicare program on the ability of physicians and hospitals to provide appropriate medical care to beneficiaries.

The Reagan administration has proposed substantial cuts in the Medicare program as part of its fiscal year 1986 budget. Although ASIM recognizes the urgent need to reduce the federal budget deficit, the Society is concerned that the Medicare and Medicaid programs are being targeted for a disproportionate share of the reductions in domestic spending. Given the fact that Medicare has already absorbed significant cuts over the past several years (as a result of the Deficit Reduction Act of 1984, the Tax Equity and Fiscal Responsibility Act of 1982, and the Budget Reconciliation Act of 1981), additional cuts in the Medicare program could have a detrimental effect on availability and quality of care rendered to Medicare patients.

RECOMMENDATIONS ON FY 1986 BUDGET PROPOSALS

Specifically, ASIM is concerned about the following proposals contained in the administration's fiscal year 1986 budget proposal:

Increasing the Medicare Part B premium and deductible

The administration proposes gradually increasing the Medicare Part B premium to 35% of estimated program costs by calendar year 1990, and allowing the Part B deductible to increase as the Medicare Economic Index increases.

Although ASIM supports the concept of increased patient cost sharing as one mechanism for placing appropriate incentives into the health care system, the Society is concerned that these proposals will place an unacceptable financial burden on many Medicare patients, particularly low income beneficiaries. It is important to recognize in 1981 Congress enacted several changes to increase patient cost sharing under the Medicare program, by increasing the Part B deductible to $75 and by providing for a more current basis for calculating the Part A deductible, thereby increasing beneficiary liability. Further increases in patient liability for Part B services could have the effects of forcing some lower income beneficiaries to discontinue supplemental medical insurance (Part B) coverage due to the higher premiums, and creating a financial barrier to receiving care as a result of the higher deductible. For these reasons, ASIM strongly opposes the administration's proposals to increase the Part B premium and deductible.

Continuation of the current Medicare freeze on reimbursement for physician services

The administration has also proposed extending the current freeze on Medicare reimbursement for physician services and on the actual charges to Medicare patient's of "non-participating" physicians.

ASIM strongly favors long term changes—such as basing Medicare's "approved amount" on a relative value scale that takes into account the time, complexity, overhead and other "resource costs" factors involved in providing each physician service—that will reduce the current incentives for high cost, technological services. But ASIM strongly opposes the administration's proposed extension of the Medicare fee freeze. During the current and proposed freeze, costs incurred by physicians—as measured by the Consumer Price Index and surveys on overhead costs—have increased, and are expected to continue to increase, at a significant rate (see attached graph). Given this reality, ASIM believes that extension of the freeze will harm Medicare patients, by resulting in curtailment of services, and possibly, higher program costs in the long run. Increased out-of-pocket costs will also result as non-participating physicians are forced to decrease the number of times they accept assignment on services in order to make up for the growing differential between Medicare's "approved amounts" and an amount that would represent an appropriate and fair "marketplace" allowance for their services.

If Congress determines that there is a need to enact some immediate measures to reduce outlays for physician services under Medicare, ASIM urges consideration of the following alternative options:

1. Extend the freeze for all services except for physicians' cognitive services—such as office visits and consultations—that currently are undervalued by the existing system. A list of cognitive services by current Procedural Terminology codes is attached.
2. Extend the freeze for those higher services with prevailing charges in each locality over a certain specified dollar level, such as $100 to $150.
3. Extend the freeze for only Part B services rendered to hospital inpatients.

The first two options would enable allowances and fees for cognitive services—those that are currently undervalued—to rise to reflect higher overhead costs. As a result, physicians would not face the same economic pressure to curtail services as would be the case with the under the across-the-board freeze. Option 3 (freeze on in hospital services only) had the advantage of applying the freeze only for the setting where the highest cost services, and the majority of Medicare physician expenditures take place. All three options also lessen the tendency of the freeze to increase patient out-of-pocket expenses, by making it more likely that physicians will accept Medicare's "approved amount" for their cognitive services as "payment in full."

Most importantly, unlike the administration's proposal, these alternatives would represent an important first step in creating appropriate incentives to reward hands-on cognitive care, rather than higher cost technological medicine.

ASIM also urges Congress to enact legislation to establish allowances for new procedures on the resource costs required to provide each service, so that as the cost and risk in providing the service decreases over time, allowances will decrease accordingly.

Freeze on hospital reimbursement

ASIM is also concerned that the proposed fiscal year 1986 freeze on hospital reimbursement will adversely affect the quality of patient care. Hospitals and physicians are already responding to the incentives built into the prospective pricing system to be more cost effective by dramatically reducing hospital admissions and length of stay and by shifting care to the outpatient setting. ASIM believes, however, that the proposed cuts in reimbursement are premature and could result in hospitals cutting or even eliminating essential services in order to meet their costs, particularly in view of recent evidence that the current DRG payment levels in some instances may be lowering the quality of care provided to Medicare patients.

A recent study by the General Accounting Office found several alarming trends resulting from implementation of PPS, specifically:

Patients are being discharged from hospitals after shorter lengths of stay and in poorer states of health than prior to DRGs.

It is not clear that post-hospital providers—including nursing homes, home community health services—are equipped to deal with these sicker patient.

The demand for post-hospital care is expected to increase under DRGs—yet there is already a shortage of nursing home beds for Medicare patients and limited coverage for services under home and community health programs in many states.

Another study by the District of Columbia Hospital Association (DCHA) found that hospitals located in large, central cities are suffering severe finanical consequences as a result of PPS. According to the study, "central city location and treatment of a large number of low income patients contribute to higher costs for city hospitals compared to their suburban counterparts. The cost per patient in the sample hospitals was $654 higher due to city location alone." The Secretary of DHHS is authorized by statute to make adjustments in the payment rate for those institutions that serve a disproportionate share of low income Medicare patients, but has neglected to do so.

ASIM believes that cutting hospital reimbursement will only exacerbate the problems identified by GAO and DCHA. Because of our early concern about the possible adverse effects of DRGs on patient care, the Society in March 1984 initiated its own survey of internists' experiences under PPS. Preliminary results of this survey, while drawn from a small sample size, corroborate many of GAO's findings. The Society plans to conduct a more scienfic survey of the effects of DRGs on patient care and will be happy to share our findings with the Committee.

For the reasons identified above, ASIM strongly urges the Committee to reject the Administration's proposed fiscal year freeze on hospital reimbursement.

Reductions in funding for medical education

ASIM also has some concern over the administration's proposals to make changes in Medicare support for medical education without adequate study.

Although ASIM agrees that there is a need to consider whether or not post medical school education can best be supported by public and private financing programs other than Medicare, the Society strongly believes that support for medical education should not be withdrawn or reduced significantly until such a study is undertaken and alternative funding sources identified. Abrupt change in Medicare support for post medical school education could have a major adverse effect on the hospitals now receiving Medicare funds, on health professionals currently in training programs, on individuals considering future careers in the health care professions, and ultimately, the general public, who could suffer if there is a sudden interruption in the availability of trained clinicians. Nevertheless, ASIM recognizes that there may be more appropriate long-term funding sources for post medical school education, and thus supports continued study of this important concept.

Specifically, ASIM recommends the appointment of a commission or task force to explore alternative sources of funding for post medical school education. Such a commission, if mandated by Congress, should be established in such a way as to assure a broad base of representation, including physicians (both academic and practicing physicians), nurses and other health professionals, hospital administrators, representatives of Medicare beneficiaries, governmental officials, representatives of the private insurance industry, medical students and residents, and other appropriate individuals with expertise and interest in this subject. To assure that the commission develops recommendations that are not perceived to be self-serving, it is essential that its membership be as broad based as feasible and not be confined solely to those individuals and facilities (health professionals in training and hospitals) directly affected by the issue. Such individuals, however, certainly should be included in the commission's membership.

Therefore, ASIM recommends that Congress consider—as an alternative to making significant changes in Medicare support for post medical school education at this time—mandating the establishment of a commission (with representation as described above) that would be charged with making recommendations to DHHS and Congress on the feasibility of alternative sources of funding for post medical school education.

OTHER ALTERNATIVE PROPOSALS

ASIM also believes that more emphasis must be placed on increasing revenue for the Medicare program, rather than further cuts in expenditures, as a means of reducing the federal deficit and improving long-term solvency of the Medicare program. Specifically, ASIM believes strongly that the excise taxes on tobacco products should be doubled to 32 cents per pack, rather than decreased from the present level of 16 cents per pack to 8 cents per pack on January 1, 1986, as mandated under current law. A large and growing body of research literature clearly demonstrates that individuals that use tobacco products incur disproportionately higher medical expenditures over their lifetimes. On a national scale, the economic toll of smoking is estimated to cost $49 billion annually. Of this sum, $15 billion in medical care resources, more than five percent of the nation's total direct health care costs, is consumed as a result of smoking related illnesses. Cigarette smoking, by consuming large amounts of the nation's health care resources, places an average economic burden on each non-smoking, working age, American adult of more than $100 in taxes and health insurance premiums. Because smokers generate higher health care costs, subsequently increasing Medicare expenditures, it is reasonable to expect buyers and users of tobacco to contribute a larger amount of revenue to the Medicare program.

Further, an increase in the federal excise tax on tobacco products has substantial revenue raising capacity. In one year, the 16 cents tax raised over $5 billion for the federal treasury. According to the Department of the Treasury, an increase to 32 cents per pack of cigarettes—the level that the tax currently would be if it had been adjusted for inflation yearly since 1951—will produce $8.5 billion a year in revenue. However, if the tax returns to 8 cents per pack, the yielded revenue would drop to $2.5 billion a year.

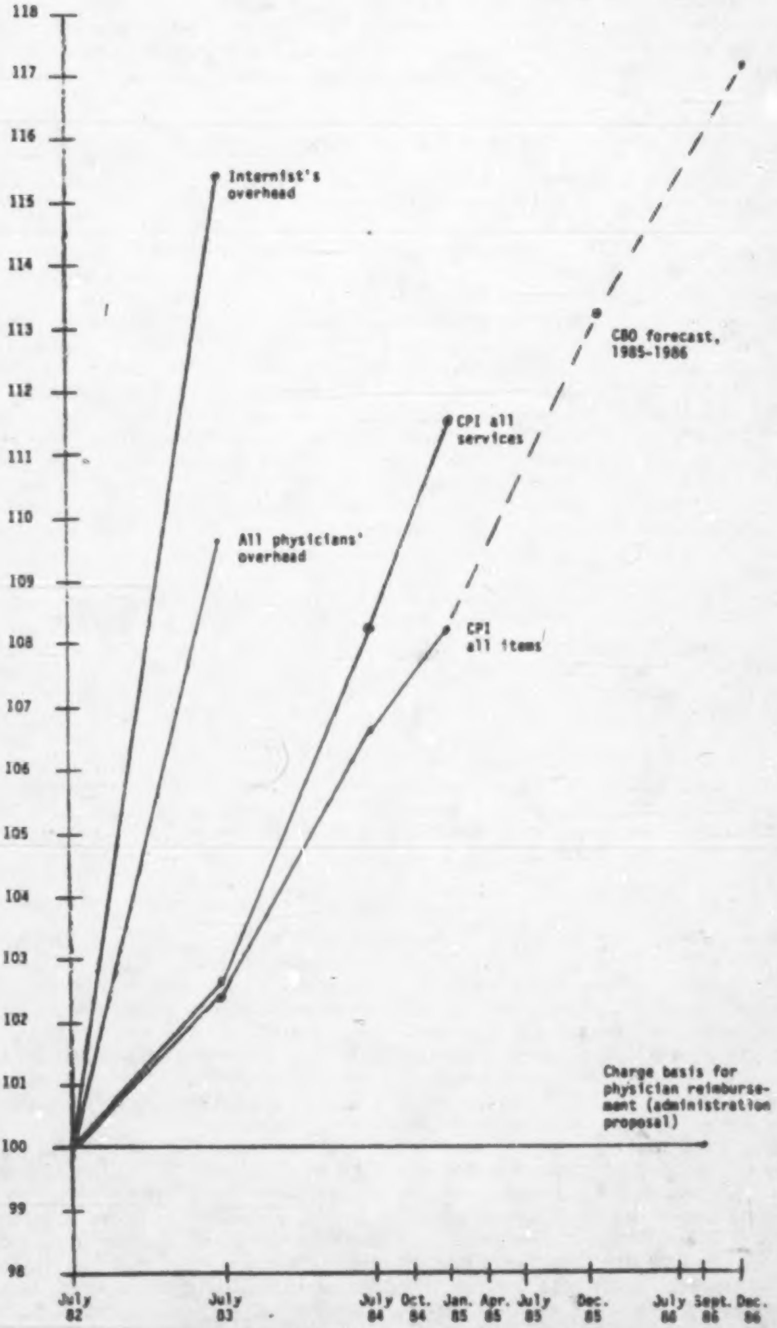
Therefore, ASIM strongly recommends that Congress increase the federal excise tax on tobacco products to 32 cents per tax, with the revenue to be earmarked to the Medicare Part A trust fund. At a minimum, Congress should repeal the rollback provision of the Tax Equity and Fiscal Responsibility Act of 1982, prior to October 1985, to maintain the existing 16 cents excise tax.

CONCLUSION

ASIM recognizes the necessity of reducing the federal deficit. The Society feels strongly, however, that the Medicare program should not be singled out for disproportionate cuts in domestic spending. Further, rather than focusing on short term, stop gap measures to reduce Medicare expenditures, ASIM believes that Congress should focus on long term reform of the financing and benefit structure of the Medicare program. ASIM has developed a series of long term recommendations for improving the physician reimbursement system under Medicare, and for improving the long term solvency of the program. The Society would welcome the opportunity to share these recommendations with Congress.

The administration's proposals to increase the Medicare Part B premium and deductible (with no protection for low income beneficiaries), to extend the current freeze on Medicare reimbursement for physician services, to freeze reimbursement to hospitals under the Medicare prospective pricing system, and to make changes in Medicare support for post medical school education without identifying alternative sources of funding are ill-advised and should be rejected by Congress. If Congress believes that legislative changes in the Medicare program are needed this year, ASIM urges consideration of the following alternatives (1) fine tuning the administration's across-the-board freeze on reimbursement for physician services by making it selective (i.e., exempting those physician services that currently are undervalued); (2) increasing federal excise taxes on tobacco to 32 cents per pack, and earmarking the funds for the Medicare program; and (3) mandating the establishment of a commission to identify alternative sources of financial support for post medical school education.

ATTACHMENT A



Changes in CPI, Physicians' Overhead and Charge Basis for Determining Allowances for Physician Services during Fee Freeze since July 1982 (standardized to 100 at July 1982 levels)

Note: Each increase of 1 unit over 100 represents a 1% increase over July, 1982 levels.

Table I.

ATTACHMENT B

COGNITIVE SERVICES BY CPT CODES AND DESCRIPTIONS

MEDICINE

OFFICE MEDICAL SERVICES

NEW PATIENT

90000 Brief service
90010 Limited service
90015 Intermediate service
• 90017 Extended service
90020 Comprehensive service

ESTABLISHED PATIENT

90030 Minimal service
90040 Brief service
90050 Limited service
90060 Intermediate service
90070 Extended service
90080 Comprehensive service

HOME MEDICAL SERVICES

NEW PATIENT

90100 Brief service
90110 Limited service
90115 Intermediate service
90117 Extended service

ESTABLISHED PATIENT

90130 Minimal service
90140 Brief service
90150 Limited service
90160 Intermediate service
90170 Extended service

HOSPITAL MEDICAL SERVICES

NEW AND ESTABLISHED PATIENT

INITIAL HOSPITAL CARE

90200 Brief history and examination, initiation of diagnostic and treatment programs, and preparation of hospital records
90215 Intermediate history and examination, initiation of diagnostic and treatment programs, and preparation of hospital records
90220 Comprehensive history and examination, initiation of diagnostic and treatment programs, and preparation of hospital records

SUBSEQUENT HOSPITAL CARE

90240 Brief service
90250 Limited service
90260 Intermediate service
90270 Extended service
90280 Comprehensive service

HOSPITAL DISCHARGE SERVICES

(Final day of a multiple day stay)
(For a single day hospital care, use appropriate Initial Hospital Care 90200-90220)

Final Hospital Care for discharge of a patient when it includes final examination of the patient, discussion of the hospital stay, instructions for continuing care, and preparation of discharge records.

• 90292 Hospital discharge day management

SKILLED NURSING, INTERMEDIATE CARE, AND LONG-TERM CARE FACILITIES

Convalescent, rehabilitative or long-term care involves active, definitive, professional care of a patient

NEW OR ESTABLISHED PATIENT

INITIAL CARE

90300 Brief history and physical examination, initiation of diagnostic and treatment programs, and preparation of hospital records
90315 Intermediate history and physical examination, initiation of diagnostic and treatment programs, and preparation of hospital records
90320 Comprehensive history and physical examination, initiation of diagnostic and treatment programs, and preparation of hospital records

SUBSEQUENT CARE

90340 Brief service
90350 Limited service
90360 Intermediate service
90370 Extended service

NURSING HOME, BOARDING HOME, DOMICILIARY, OR CUSTODIAL CARE MEDICAL SERVICES

Domiciliary or custodial care involves periodic services provided to a patient who is institutionalized on a long-term basis

NEW PATIENT

90400 Brief service
90410 Limited service
90415 Intermediate service
90420 Comprehensive service

ESTABLISHED PATIENT

90430 Minimal service
90440 Brief service
90450 Limited service
90460 Intermediate service
90470 Extended service

EMERGENCY DEPARTMENT SERVICES

NOTES

The following listings may be used by the physician to report his services when he is assigned to the emergency department or is present in the emergency room because of other activity there, or if the physician elects to use the emergency room as a substitute for his office. (For physicians not assigned to the emergency room, see 99062-99065)

NEW PATIENT

90500 Minimal service

90505 Brief service
90510 Limited service
90515 Intermediate service
90517 Extended service

ESTABLISHED PATIENT

90530 Minimal service
90540 Brief service
90550 Limited service
90560 Intermediate service
90570 Extended service

CONSULTATIONS

For descriptions of levels of consultation, see page 5
90600 Limited consultation
90605 Intermediate consultation
90610 Extended consultation
90620 Comprehensive consultation
90630 Complex consultation

OTHER PROCEDURES

90699 Unlisted medical service, general

CRITICAL CARE

Critical care includes the care of critically ill patients in a variety of medical emergencies that requires the constant attention of the physician (cardiac arrest, shock, bleeding, respiratory failure, postoperative complications, critically ill neonate). Critical care is usually, but not always, given in a critical care area, such as the coronary care unit, intensive care unit, respiratory care unit, or the emergency care facility. The descriptors for critical care are intended to include cardiopulmonary resuscitation and a variety of services attendant to this procedure as well as other acute emergency situations. Separate procedure codes for services performed during this period, such as placement of catheters, cardiac output measurement, management of dialysis, control of gastrointestinal hemorrhage, electrical conversion of arrhythmia, etc., are excluded when this descriptor is used on a per hour basis. The physician may list his services separately if he does not wish to use this classification.

99160 Critical care, initial, including the diagnostic and therapeutic services and direction of care of the critically ill or multiple injured or comatose patient, requiring the prolonged presence of the physician; each hour

99162 additional 30 minutes

• 99171 Critical care, subsequent follow-up visit; brief examination, evaluation and/or treatment for same illness

• 99172 limited examination, evaluation and/or treatment, same or new illness

• 99173 intermediate examination, evaluation and/or treatment, same or new illness

• 99174 extended re-examination, re-evaluation and/or treatment, same or new illness

ASSOCIATION OF ACADEMIC HEALTH CENTERS,
Washington, DC, April 8, 1985.

Representative FORTNEY H. STARK,
Subcommittee on Health, House Ways and Means Committee, Longworth House Office Building, Washington, DC.

DEAR CONGRESSMAN STARK: The Association of Academic Health Centers represents approximately one hundred American and Canadian institutions of higher education whose chief administrative officers—presidents, chancellors, vice presidents for health affairs and others—share with the deans of their respective health professions schools (medicine, dentistry, nursing, etc.) and with the directors of their principal teaching hospitals the responsibility for these institutions' educational, research and patient care mission and fiscal stability.

I am writing to express a perspective on the issue of Medicare payments for graduate medical education, for inclusion in the record of the Health Subcommittee's April 15 hearing on proposed FY 1986 Medicare budget savings.

Clearly, the federal government has a responsibility to review Medicare and Medicaid costs, including those related to graduate medical education, to determine which it should pay. The current federal budget deficit and longer-term Hospital Insurance Trust Fund situation make this review urgent. However, we believe that in the process your Committee should be very careful not to assume responsibility for determining what types of physicians and other health professionals will be needed to treat Medicare beneficiaries, how many of each specialty will be needed, how long their training should take, or what the curriculum content should be. A number of the proposals for reducing Medicare financing of graduate medical education programs, recently discussed in public or private, could result inadvertently in giving the government and Medicare this responsibility.

As you are well aware, health care in the United States is in a state of great change. Advances in clinical technology, flux in the supply of health professionals, new ways of organizing health services (such as HMOs), the aging of our population, and changes in financial incentives for health care providers, are having a profound effect on patterns of patient care and utilization of services and are influencing health professionals' career choices. For example, a greater percentage of medical school graduates are now entering primary care specialties; graduate medical programs are moving to accommodate them; and more opportunities are being sought for training in ambulatory care settings.

It is not clear where all of these changes will lead. Some trends seem predictable—such as the movement toward providing more care on an ambulatory basis and less on an inpatient basis. But, specifically what health care will be offered, in what manner, by what types of specialists is uncertain. This uncertainty is compounded by the likelihood that new technologies and ways of financing and organizing care will change the direction of some current trends of patient care delivery, perhaps increasing the need for types of health professionals and specialists that may seem in oversupply at present. This is particularly true of care for the elderly, whose increased longevity and better health in advanced years are raising a host of new medical, ethical, and organizational challenges.

In this unpredictable environment, I do not believe it is possible to define future manpower needs with any precision for either the nation at large or the Medicare population in particular. We are concerned, however, that budget pressures might prompt your Committee and Congress to define manpower needs more definitively than is appropriate in order to be able to justify deeper reductions in Medicare and Medicaid payments. What is reasonable and affordable for Medicare and Medicaid to pay for graduate medical education can and should be decided without trying to establish definitive manpower needs. We urge you to leave maximum flexibility to the marketplace, the universities, and credentialling/accrediting agencies to modify curriculum and requirements in response to the powerful changes taking place in health care.

Let me offer an example of this distinction with regard to several of the more easily misunderstood proposals that have been discussed. I submit that if your Committee were to limit Medicare's direct graduate medical education payments, as some are suggesting, so that they would fund the cost of no more than a specific number of years of residency training per medical graduate, it should do so because it believes that the formula would produce funding levels that are generally responsible and affordable for the Medicare program. Such a step should not be taken on the grounds that the government considers a specific number of years to be sufficient preparation for physicians, or that Medicare's only need for the foreseeable future is for additional physicians of a given specialty. The same distinction should apply to other policy proposals, such as prescribing ratios of primary care to total residencies a teaching hospital must have in order to be eligible for graduate medical education cost reimbursement under Medicare.

Medicare and your Committee have maintained a long tradition of avoiding regulation of the university. As the health professions component of the university, we appreciate and respect this tradition, and urge that it be continued. The Association of Academic Health Centers, and I on its behalf, would be pleased to work with you and your Committee to suggest policy refinements and clarifying language consistent with this tradition.

Sincerely,

JOHN R. HOGNESS, M.D., *President.*

ASSOCIATION OF ACADEMIC HEALTH CENTERS,
Washington, DC, April 30, 1985.

Hon. FORTNEY H. STARK,
Subcommittee on Health, House Ways and Means Committee, Washington, DC.

DEAR CONGRESSMAN STARK: The Board of Directors of the Association of Academic Health Centers has recently adopted a position on Medicare payments for residencies and other training programs in American teaching hospitals. We are pleased to submit a copy of the *Statement* for your attention, and will welcome questions you may have concerning it.

Sincerely yours,

JOHN R. HOGNESS, M.D.,
President.

Enclosure.

ASSOCIATION OF ACADEMIC HEALTH CENTERS

MEDICARE FINANCING OF GRADUATE MEDICAL EDUCATION AND OTHER TRAINING PROGRAMS IN TEACHING HOSPITALS, APRIL 26, 1985

The following Statement of Principles relative to Medicare payments for residencies and other training programs conducted in American teaching hospitals represents the position of the Board of Directors of the Association of Academic Health Centers.

The Board of Directors is the governing body of the Association of Academic Health Centers. The Association of Academic Health Centers is composed of approximately one hundred American and Canadian institutions of higher education whose chief administrative officers—presidents, chancellors, vice presidents for health affairs and others—share with the deans of their respective health professions schools (medicine, dentistry, nursing, etc.) and with the directors of their principal teaching hospitals the responsibility for these institutions' educational, research, and patient care mission and fiscal stability.

STATEMENT OF PRINCIPLES

The cost of graduate medical education programs has traditionally been recognized by government and by private payors as an expense teaching hospitals should recover through charges for services rendered to patients. With the enactment of the recent Medicare legislation, and the introduction of the prospective payment system for Medicare patients, Congress has reaffirmed the legitimacy of financing graduate medical education through revenues from hospital patient services, by providing in the law means for the continuation of the pass-through of direct educational costs, as they apply to the Medicare program.

The current federal budget deficit and the pressures for stabilizing the Hospital Insurance Trust Fund have prompted the Administration and Congress to reexamine graduate medical education financing, and to reevaluate the federal government's approach in its continued fiscal support of graduate medical education programs. Among the justifications advanced by those who propose that federal payments toward graduate medical education should be reduced is the argument that the current system of subsidies for residencies is open ended, and has thus helped produce a surplus in some specialities, without solving the problem of geographical maldistribution and uniform access to primary care physicians. Legislative approaches aimed at cutting the federal share of the costs have been proposed, ranging from arbitrary freezes of the amount Medicare would pay (regardless of actual costs) to elimination of payments to specialty programs perceived by some as not being needed for the care of Medicare patients.

While we recognize the need to balance federal receipts and outlays, we submit that hasty, excessive or highly targeted reductions in the funds which support graduate medical education could bring about long-term damage to valuable aspects of a system which has made American medicine preeminent in the world, and could constrain the ability of universities to meet the health professional manpower requirements of the nation as new needs emerge.

We respectfully submit the following six principles for consideration by federal agencies and by Congress in approaching new legislative measures to regulate Medicare payments for graduate medical education:

1. Reduction of residency-related Federal expenditures

The Medicare program currently makes no distinction between residency positions filled by graduates from the medical schools accredited by the Liaison Committee in Medical Education or by the Bureau of Professional Education of the American Osteopathic Association on the one hand, and graduates from foreign medical schools not accredited by the above bodies on the other.

While there may have been some justification for this practice in past years when the physicians' supply was felt to be less than needed, it is unnecessary now when the system is in near balance between number of residency positions offered in the United States and number of physicians graduating from accredited medical schools.

We have long opposed the practice of allowing entry into the American health system to individuals with doubtful credentials, and firmly believe that:

(a) The government should not continue to encourage the practice of accepting foreign medical graduates into accredited residency positions by funding these individuals' graduate medical education cost under Medicare or other programs.

(b) The elimination of such U.S. government funding for foreign medical graduates' residency training in the United States would not impair the U.S. health care system, but would in fact improve the quality of its medical manpower pool.

At the present time, about 18 percent of the residency training positions in the United States are filled by physicians graduated from non-accredited schools. We submit that the elimination of Medicare payments for the costs incurred in training these individuals would produce most of the reduction sought in Medicare expenditures for graduate medical education, without any corresponding decline in the ability of the educational system to maintain a flow of quality physician manpower. In the few states in which certain types of hospitals still depend on foreign medical graduates for staffing, we recommend that the individual states assume the responsibility for paying these residents.

2. Support for residency training leading to initial board certification

We recognize that the current practice of indefinite support for residency training, including the entire term leading to subspecialty board certification, may represent an inducement for candidates to elect continuation of training into subspecialities, irrespective of manpower needs. We believe that once physicians achieve certification in a primary speciality (the length of time required varies with each specialty) financing of the continuation of their training in a subspecialty should be assumed by the trainees themselves or by others, but not the federal government.

We strongly recommend that funding of residency training for the number of years now required for initial board certification of physicians and dentists be continued in essentially the same way as currently practiced, i.e., through reimbursement to the hospital of the expenditures now allowed under the "direct cost" definition. Further, in order that educational institutions are allowed more flexibility in training residents in ambulatory care settings, and so emphasize the primary care specialties, we recommend that the teaching hospitals be permitted discretion in the utilization of the funds they receive for graduate medical education.

3. Equalization of residents' stipends

We recommend that the portion of the resident's stipend recognized eligible for Medicare reimbursement should be the same for all residents in all hospitals, for all specialties, except for adjustments proportional to the cost of living index in different areas in the United States; that the uniform base be adjusted annually for changes in national cost of living indices; and that a modest amount be added for each year of seniority.

4. Educational costs of programs other than medicine

Teaching hospitals incur costs for the training of health professionals other than physicians, such as pharmacists, nurses, dentists, allied health technologists and others. These professionals are indispensable to the functioning of our health care system; support of their training is of critical importance, even though the amount of funds contributed by the federal government is small compared to those for graduate medical education.

We urge that the current provisions for the reimbursements to hospitals of the teaching costs of educating health professionals other than medicine be continued.

5. *"Indirect cost" proxy*

When Congress enacted the legislation which put in place a prospective payment system, it recognized that teaching hospitals bear extraordinary costs which are due to such factors as intensity of care, severity of illness, predominantly inner city location, disproportionate ratio of uncompensated care, etc. These characteristics, plus costs originating from the hospitals' teaching mission but not quantifiable under the "direct" cost rubric, lead to the introduction of an adjustment to the per-admission (DRG) rate, which came to be called the "indirect cost" proxy.

Studies initiated since the enactment of the legislation, and to be completed in the near future, are attempting to identify the nature and extent of these extra costs. Information available to date indicates that the costs attributable to "teaching" are small compared with those attributable to the unusual "service" factors in teaching hospitals. Yet some mistakenly regard the "indirect cost" adjustment as another teaching cost pass-through, and argue for an immediate 50 percent reduction of the payments allowed under the formula.

We strongly urge Congress to leave the existing "indirect costs" proxy in place until the results of studies to clarify the factor causing these extra teaching hospital costs are completed, and appropriate new measures can be designed.

Should the necessity for cutting the national budget deficit make it mandatory that some savings be achieved this year from the Medicare "indirect costs" proxy, we strongly urge that the proxy formula not be cut below the 9 percent per .1 resident per bed. Preliminary information from studies now in process seem to indicate that this may be an appropriate level of support.

6. *Control of training programs*

We are concerned that in the process of seeking a solution to the cost problem Congress may inadvertently insert the federal government into areas of judgment traditionally reserved to the university. For example, casting into legislation the number and types of health professionals to be trained, quotas for specialties, length of training, curriculum, etc., under the guise of cost reduction or stimulation of responses to market needs.

Health care in the United States is in a state of transition. Advances in clinical technology, flux in the supply of health professionals, new ways of organizing health services, the aging of our population, the changes in financial incentives for health care providers, are having a profound effect on patterns of patient care and utilization of services, and are influencing health professionals' career choices. It is not clear where all these changes will lead. Some trends seem predictable, such as trends to more ambulatory care, but, specifically what health care will be offered, in what manner, by what types of specialists is uncertain. It is possible that new technologies and new organizational forms of providing patient care may emerge which will change current trends of health care delivery perhaps increasing the need for types of health professionals and specialists that may seem to oversupply at present.

In this unpredictable environment we do not believe it possible to define future manpower needs with any precision, and for this reason we urge that maximum flexibility be left for the teaching institutions responsible for the residency programs to modify programs and curricula as changes take place in the health system. Legislative initiatives which would freeze funding in relation to perceived present needs or designed to provide stimuli for satisfying the current demands of the marketplace ignore the time lag (considerable in some cases) for the training of competent professionals.

Home Health Agency Assembly of New Jersey, Inc.,
Princeton, NJ, April 9, 1985.

Hon. Fortney H. Stark,
Chairman, Subcommittee on Health, Committee on Ways and Means, U.S. House of Representaitves, Longworth House Office Building, Washington, DC.

Dear Representative Stark: Thank you for informing us of the hearing on the Medicare budget, which is scheduled to take place on April 15 and 16, 1985. I have enclosed six copies of two documents which we feel are relevant to your inquiry:

1. Correspondence to the N.J. Congressional delegation on impact of proposed budget cuts on Medicare and Medicaid home health care beneficiaries; and
2. Testimony before the Forum of Alternative Reimbursement for Home Care.

New Jersey's five year experience with prospective pricing for hospital care has taught us important lessons which should be taken into account as the federal Medicare program fully implements its prospective pricing system.

Thank you for the opportunity to share this information.

Sincerely,

JOHN PAUL MAROSY, *Executive Director.*

Enclosures.

HOME HEALTH AGENCY ASSEMBLY OF NEW JERSEY, INC.,
Princeton, NJ, March 15, 1985.

Hon. BILL W. BRADLEY,
Hart Senate Office Building,
Washington, DC.

DEAR SENATOR BRADLEY: President Reagan's proposed budget for fiscal year 86, if adopted, would have a devstating impact on the lives of thousands of elderly and low income patients of New Jersey's certified home health agencies. The proposals restrict access to needed home health care, place an even greater financial burden on those least able to pay for health care, and eliminate the health planning function which has been so vital to the growth of quality home health care in the State of New Jersey.

1. ACCESS TO HOME HEALTH CARE

By seeking to impose a cap on Medicaid, the Administration imperils New Jersey's proposed Medically Needy program, which would open up needed medical care for elderly, poor and disabled persons who are now just above Medicaid eligibility limits. We estimate that cost-effective home health care benefits would be denied to a minimum of 1,300 medically needy elders per month who would have benefited from this new program which is included in Governor Kean's budget.

2. COPAYMENT FOR MEDICARE HOME HEALTH BENEFITS

A copayment equal to one percent of the Medicare inpatient hospital deductible would be charged for each home visit after 20 each year ($4.80 in 1986). Staff of the Senate Select Committee on Aging estimate that this would impact about one-third of all Medicare home health patients—a total of 22,645 New Jerseyans. The proposed gradual rise in the Part B premium would further raise out of pocket costs for the elderly, many of whom find that the current level of cost sharing requires sacrifices in their standard of living.

3. ELIMINATION OF HEALTH PLANNING

The network of Health System Agencies (HSAs) play a vital role in assuring public input in planning for health care and assuring cost-effectiveness and quality in the system. The five HSAs in New Jersey have played a key role in implementing the state's Certificate of Need (CON) law. In New Jersey, CON for home health care has allowed for planned growth in the number of providers (increase of 25% over the past three years), while stimulating development of more responsive services and helping to assure quality of care, especially for Medicare recipients. Of course, the cost benefits of health planning are felt in even larger degree in hospital and nursing home related decisions.

Please note, however, that in Texas, when CON for home health was removed, the cost of a nursing visit increased by 33% in one year, more than three times the rate of increase nationwide.

We realize the enormity of the proposed budget cuts in housing, income, jobs and education, affecting low income Americans. We provide this information on home health impact in the hope that you can use it to argue for a reversal in this policy. Home health care needs to be expanded to provide care for the five million Americans who currently need help. Restricting access to this type of care is penny-wise and pound-foolish, because the victims of these cutbacks will wind up in emergency rooms and nursing homes, where care is far more expensive.

Sincerely,

JOHN PAUL MAROSY, *Executive Director.*

TESTIMONY BEFORE THE FORUM ON ALTERNATIVE REIMBURSEMENT SYSTEMS FOR HOME CARE, NATIONAL ASSOCIATION FOR HOME CARE LEGISLATIVE REGULATORY CONFERENCE, BY JOHN PAUL MAROSY, EXECUTIVE DIRECTOR, HOME HEALTH AGENCY ASSEMBLY OF NEW JERSEY, INC.

Senator Moss, distinguished members of the panel, ladies and gentlemen: I am John Paul Marosy, Executive Director of the Home Health Agency Assembly of New Jersey, Inc., an organization which represents 51 of the 54 certified home health agencies in the state of New Jersey. The Home Health Agency Assembly was founded eleven years ago and is the leading voice of the home health care industry in the state of New Jersey. We are proud of the high quality of care that home health agencies provide for New Jerseyans. In addition, we are proud of the leadership that our Governor, Tom Kean, and the members of New Jersey's Congressional delegation, in particular Senator Bill Bradley, have displayed in seeking to assure access to home health care for the millions of Americans who need this help to remain in the dignity and comfort of their own homes.

In 1980, New Jersey became the first state in the nation to implement a prospective pricing system for hospital care, based on diagnostically related groups (DRG's). We have closely monitored the impact of this method of paying for hospital care on the home health care industry in New Jersey.

A data report by our organization that was just published documents three important facts:

1. The DRG system in New Jersey has increased the number of hospital referrals to home health care,
2. Home health agencies have greatly increased their provision of high technology care in the home in order to respond to the earlier discharges, and
3. Home health agencies have expanded their hours of operation to meet hospital discharge requirements.

In the remainder of my testimony, I will describe New Jersey's DRG system, report our data findings, and point out what we see as contradictions in current health care poicy which are preventing home health agencies from providing care to those in need.

NEW JERSEY'S SYSTEM OF PROSPECTIVE PRICING FOR HOSPITAL CARE

In 1980 New Jersey established a system of prospective payment for hospital care, based on DRG's, under a federal Medicare waiver contract. The Department of Health and Human Services recently approved extension of the waiver through 1987. The New Jersey system differs from the federal Medicare prospective pricing system in several important ways: First, it covers all third party payers, whereas the federal system covers Medicare only; Second, the New Jersey system covers all uncompensated care and the federal system does not; Third, rates are hospital-specific in New Jersey; Fourth, there are deliberate, due process appeals mechanisms which are more open than those in the federal system; Fifth, because New Jersey's system covers all payers, the DRG rates are set to reflect as closely as possible the resources consumed in each DRG by typical acute care hospital inpatients. Consequently, New Jersey has a much higher percentage of outliers (cases whose costs either exceeded or were significantly less than the DRG rate per case). The state felt that by removing atypical hospital inpatients from the average rate structure, quality would not be compromised. Sixth, outpatients are not excluded from the New Jersey system. They are billed on a fee per visit.[1]

It is important to note these six differences from the federal system, since they have a direct bearing on the incentives which dictate length of stay for hospital patients and the circumstances surrounding discharge planning for home health care.

IMPACT OF NEW JERSEY'S DRG SYSTEM ON HOME HEALTH AGENCIES

New Jersey's hospitals were phased into the DRG system over a three year period: 1980, 1981, and 1982. According to the New Jersey Health Department the average length of stay in 1979 (pre-DRG) for the seven most common types of licensed hospital beds was 7.43 days; this figure dropped to 7.0 days in 1982 and decreased farther, to 6.39 days in 1983.[2] By comparison, the Department of Health and

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[1] Faith K. Goldschmidt, Health Planning and Resource Development, New Jersey Department of Health, in a letter to Modern Healthcare, August 1, 1984.

[2] Health Data Summaries for 1979, 1980, 1981, 1982, and 1983, New Jersey Department of Health.

Human Services reports a reduction in average length of stay in the Medicare program from 9.5 days to 7.5 days after the first full year of the federal prospective payment system.[3] Clearly, prospective payment results in earlier hospital discharges.

In a data report, compiled in cooperation with the New Jersey Department of Health, the Home Health Agency Assembly of New Jersey found that the number of admissions to home health agencies from hospitals jumped from 61% to 68% of total admissions between 1980 and 1981, the first year of phase-in for the DRG system in New Jersey. Since 1981, hospital referrals have remained a constant 67% of total admissions for home health care. We assume that this increase during the first year of phase-in reflects the adaptation to DRG's by all hospitals in the state, in anticipating of their being phased-in. The net impact of the DRG system is an increase of 8,000 admissions to home health care in 1983. There were a total of 133,000 persons served by home health agencies in New Jersey in 1983.

Over the same four year period during which the average length of stay steadily dropped, the number of high technology services offered by home health agencies grew dramatically. We lack good baseline data because in the early 1980's high technology home care services were in such an early stage of development that they were not included in the data questionnaire check-off list. However, according to 1983 data, the following services were offered by a significant number of home health agencies:

TABLE 1.—TYPES OF PROGRAMS AVAILABLE (1983)

	Number	Percent
Home catheter care [1]	50	98.0
Tracheostomy care [1]	45	88.0
Intravenous therapy	26	51.0
Respiratory therapy (MIA respirator)	17	33.0
Chemotherapy	13	25.5

[1] Cathether care and tracheostomy care are standard procedures and 51 percent of NJ home health agencies offer some kind of high technology service such as intravenous therapy or chemotherapy.

The growth in high technology services experienced over the period paralleling the DRG implementation years suggests a relationship between the two events, explained by the introduction of more acutely ill patients into the home health care setting.

The trend to expanded hours of operation—both business hours and service hours—is the most striking change in home health agency operations since the implementation of the DRG system.[4] 82% of home health agencies in New Jersey schedule admissions and visits seven days per week, and virtually all agencies provide emergency phone and referral service around the clock. Four years ago, only 66% of the agencies offered evening and weekend coverage.

POLICY CONTRADICTIONS THWART EFFECTIVE USE OF HOME HEALTH CARE

Home health agencies in New Jersey have responded to the needs of patients being discharged earlier, due to DRG's. However, agencies throughout the state report that they are thwarted in their efforts to develop appropriate plans of care by Medicare's definition of intermittent care and be gaps in private insurance coverage for high technology home health care services.

Federal policy contradicts itself. While the prospective payment system for Medicare hospital care is intended to reduce institutional care costs by reducing length of stay, Medicare home health policy guidelines require Fiscal Intermediaries to apply increasingly restrictive criteria in claims reviews. Patients who need high-tech care at home often require a daily nursing visit to supervise that care. Currently, such daily visits are frequently interpreted as not meeting the "intermittent" care requirement, and are, therefore, unreimburseable.

The "intermittent" care requirement was promulgated in the 1960's at a time when the types of high tech home care now available were not even anticipated as possible in the home setting. In the 1980's, this policy is myopic and contradicts efforts to contain health care costs. Why will Medicare pay for needed nursing services in support of high technology care in the hospital or nursing home, often at double or triple the cost, but not at home?

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[3] "Medicare Limits Make Hospitals Careful on Costs," the New York Times, August 26, 1984, p. 1.

[4] Taylor, M., "1983 Home Health Data—Home Health Agencies In New Jersey," Home Health Agency Assembly of New Jesey, Inc., Princeton, NJ, March 1985.

Private insurers have some catching up to do, too. Most policies lack home health care coverage, or pay for only a portion of the cost of care, rather than the 100% coverage of most procedures performed in an institution. This is a clear disincentive to use of less costly home health services for the post-acute patient.

In conclusion, we believe that the experience of home health agencies in New Jersey since the implementation of prospective payment for hospital care shows that it is high time for Congress and the business community to re-shape health care policies to remove this wasteful and inhumane policy contradiction. The number of persons falling into the "No Care Zone" is increasing. The problem needs to be addressed now.

Thank you.

STATEMENT OF WILLIAM S. HOFFMAN, PH.D., DIRECTOR, SOCIAL SECURITY DEPARTMENT, INTERNATIONAL UNION, UNITED AUTOMOBILE, AEROSPACE & AGRICULTURAL IMPLEMENT WORKERS OF AMERICA (UAW)

The UAW is painfully aware of the scope of the problem presented by the budget deficit. Its impact on the U.S. trade deficit has resulted in the loss of millions of American jobs. What we do not accept is the notion that the best way to solve the budget crisis is to further punish the twenty-eight million aged Americans and the three million disabled and end-stage renal patients who depend upon the Medicare program to shield them from the high cost of medical care. An alternative to shifting more of the public responsibility for health care to the elderly and the private sector in general would be comprehensive legislation to actually contain costs in the total health care system and to begin to reform health care financing in a meaningful way.

A recent GAO preliminary report suggesting that Medicare's prospective payment system may be resulting in some premature discharges of hospital patients demonstrates the need to provide assurances that cost containment measures will not undermine the quality of care. While the UAW shares this concern, we are convinced more than ever that there is much fat in the health care system that, if trimmed, could result in significant savings to both governmental and private sector health care programs. It is in this spirit that we have considered the merits of the Medicare proposals contained in the Reagan Administration's budget for fiscal year 1986. Our analysis has shown that the net effect of the White House proposals would be to shift health care costs rather than to contain them. We are therefore opposed to the Administration's 1986 Medicare budget proposals. We urge Congress instead to enact meaningful health care cost containment legislation, such as the proposed Medicare Solvency and Health Care Financing Act of 1985 (H.R. 1801) which has been introduced by Representative Richard Gephardt.

The UAW's views regarding the specific Reagan Administration proposals affecting Medicare are as follows:

1. Delay eligibility to the first full month after a beneficiary's 65th birthday.

This proposal at best will simply shift costs to private sector health care plans, and at worst could expose millions of Americans to a potentially ruinous gap in health care protection.

2. Establish a "nominal" copayment of $4.80 per visit for home health care visits exceeding 20 visits per year.

The home health care program was designed to encourage less costly options to expensive inpatient hospial care. We find it illogical for the Administration to propose cost-sharing which will undermine that goal.

3. Freeze Medicare prospective payment rates to hospitals at mid-year 1985 levels.

The UAW is concerned that this proposal will further encourage the premature discharge of hospital patients indicated by the recent GAO report. We are also concerned that instead of actually containing health care costs, hospitals will attempt to maintain their revenues by shifting more of the costs to private payers, including both negotiated health care plans and individual consumers.

4. Increase Part B premiums to cover 35% of programs costs over a five year period in annual increments of 2%.

Index the Part B deductible annually according to the Medical Consumer Price Index (MCPI) starting in FY 1987.

These two proposals would result in thousands of poor and near-poor aged Americans being forced to forgo this essential health care coverage. Under the terms of these proposals, it is estimated that the monthly premium for Medicare Part B coverage would be increased from $20.80 to $32.90 by 1990. This respresents, in effect, a reduction of Social Security benefits because most beneficiaries pay their Medicare Part B premiums by deduction from Social Security checks.

5. Extend the current 15 month freeze on physicians' fees for an additional 12 months.

When the initial freeze was passed, the promise was that physicians who accepted Medicare assignment as payment in full (less statutory copayments and deductibles) for all cases would receive certain incentives for becoming "participating physicians". By reneging on the guarantee that fee increases by "participating physicians" would be recognized in future fee schedules, this proposal seriously undermines the concept of encouraging providers to accept Medicare assignment across-the-board. More important, unless beneficiaries are protected from extra billing by non-participating physicians, this measure would amount to a serious erosion of program benefits.

6. A resurrected plan to offer voucher toward payment for private insurance in lieu of Medicare.

This proposal would be a retreat from Medicare's goal of protecting the nation's elderly from the high cost of health care. Returning the responsibility for the program to the private sector which failed so miserably to meet the needs of the elderly prior to the enactment of Medicare is not an acceptable answer to Medicare's problems.

7. A plan to extend to working beneficiaries over age 69 the provision that makes employer-based private insurance the first payer for working beneficiaries between ages 65 and 69.

This proposal would simply shift costs from the government to workers and their employers; it does nothing to contain health care expenditures.

8. Freeze payments for direct medical education at current levels and reduce payments for indirect medical education by 50%.

The problem of payments for the high cost of medical education needs to be addressed by a broad national policy. Some private sector employers have also been balking at recognizing this cost in their employee insurance plans. We need a national policy which (a) matches the numbers and types of professionals that are trained to care for the health needs of the population and (b) includes adequate and equitable financing for such training.

In conclusion, the UAW opposes the Administration's proposed Medicare cutbacks because none of them will alleviate the burden the high cost of health care represents to society, and because most of them represent sharp increase in health care costs for our elderly, sick and disabled citizens. Furthermore, a review of the history of Reagan Administration budgets shows that Medicare beneficiaries have already borne an unfair share of efforts to reduce the budget deficits. Accordingly, there is no justification for calling upon Medicare beneficiaries to make further sacrifices.

STATEMENT OF DENIS ABELSON, M.D., F.R.C.P., THE LANKENAU HOSPITAL, PHILADELPHIA, PA

APPEALS PROPOSAL

The intent of these proposals is to permit profile committees to adjust reimbursement to physicians in cases where this can clearly be shown to be inadequate.

If regulations were promulgated that interim profile adjustments would be permitted under Medicare (as they have been under Blue Shield), it would merely be necessary to establish a procedural mechanism and criteria, e.g.,

1. If a doctor's customary charge was more than x% below prevailing, or
2. If he had not received an update in two profile adjustments prior to the freeze, or
3. If special circumstances in his practice had produced undue hardship, e.g. if his profile had been lowered just prior to the freeze.

he would be eligible to request an interim profile adjustment which would be done on a procedure-by procedure basis. A letter would be issued to the carrier with instructions on how to perform these updates. If the profile department rejects the physician's application it should be possible for him to request a fair hearing.

STATEMENT OF BARRY M. SPERO, PRESIDENT, THE MOUNT SINAI MEDICAL CENTER, CLEVELAND, OH

Mr. Chairman, members of the Subcommittee, thank you for this opportunity to share with you our views on the issues surrounding the Medicare Prospective Payment Program for inpatient hospital services.

I am Barry Spero, President of The Mt. Sinai Medical Center of Cleveland, Ohio. The Mt. Sinai Medical Center is a 450-bed teaching hospital affiliated with the Case Western Reserve University School of Medicine. In 1984, there were nearly 16,000 patients admitted for inpatient care, of which about 35% were Medicare beneficiaries.

The legislation and subsequent regulation which implemented the DRG scheme for payment for hospitals is the most significant development we have witnessed in health care delivery in this country since the creation of the Medicare program itself twenty years ago.

Since the inception of the DRG prospective payment program, we feel that The Mt. Sinai Medical Center and most hospitals similarly affected have responded in very positive ways to the new incentives that the PPS introduced. We operate under a lean expense budget and have optimized the use of our resources without compromising excellence in the quality of care we deliver. We reduced the average length of hospital stay for all of our patients by more than one full day in the first year of PPS, and our Medicare patients in particular were hospitalized two full days less on the average in 1984 than they were in 1983. We expect further enhancements in our operating performance to be achieved as we continue to work with our medical staff and develop hospital information reporting systems that will be useful to them in allocating hospital resources even more prudently and cost-effectively.

Our success and the success of our hospital peers in these efforts is evident nationwide. The new payment system was to be "budget neutral;" that is, the Congress expressly prohibited Medicare outlays for inpatient hospital services under the new program from exceeding what they would have been under previous payment methodologies. In fact, Medicare outlays in the first fiscal year under PPS were nearly $3 billion or 7% below what would have been spent under cost reimbursement principles. Although the immediate results of the program's implementation seem to have been favorable for the government, from the perspective of the hospitals and the citizens of our communities, we are somewhat wary of what the future holds.

Our short range plans have been concerned primarily with resolving the difficulties which surfaced in 1984 and with addressing further complications which we know will occur in future years. Regardless of how encouraging our early experience with the DRG payment program has been, certain flaws and weaknesses inherent in the plan have been recognized.

THEORETICAL FLAWS

As the very foundation of the PPS program is an assumption that a hospital has the ability to manage cost and volumes of care furnished to its Medicare patients in a manner that gives all hospitals equal opportunity to be "winners" under the plan. The payment system fundamentally rewards hospitals which allocate resources prudently and penalizes hospitals which do not. The problem we face is that hospitals do not admit patients, they do not prescribe care during the patient's hospital stay, and they do not determine when the patient's recovery is sufficient for discharge. These are, and will remain, the responsibilities of the physician who unfortunately is responding to a set of Medicare payment incentives that are quite contrary to those of the hospital. Yes, we can influence the physician, but we do not make the final determinations.

The DRG prospective payment system further assumes that Diagnosis Related Groups, of which 468 are currently recognized, is a statistically valid and medically meaningful way to classify nearly 10,000 diagnosis and procedure codes in the International Classification of Diseases, Ninth Revision, Clinical Modification, a voluminous reference test. First, the DRGs do not appear to be statistically valid. For a substantial number of DRGs, the standard deviation of patients' lengths of stay is greater than the geometric mean of patients' lengths of stay. Second, we have no way of knowing if the DRGs are, in fact, medically meaningful when their relative values are expressed as an aggregated index and not in terms of distinct treatment protocols. The opinion has been expressed by members of our medical staff, however, that these gross categories cannot represent homogeneous clinical profiles. For example, the DRG for hepatitis makes no exception for patients suffering End Stage Renal Disease even though our renal patients are frequently hospitalized with this condition and receive thousands of dollars worth of dialysis treatment while the hepatitis is being brought under control. The DRG classification scheme does not recognize severity of illness or disease stages. Obviously, a person with a history of diabetes is not treated for a broken leg the same way and in the same measure as a relatively healthy person with a broken leg, and cardiac arrest is not nearly as dangerous or as resource intense for a healthy, working adult male in his forties as it is for a retiree with a history of coronary episodes. While it is true that the law of averages within a hospital will resolve the inequities to some extent, this may not be true for hospitals which consistently care for a more acutely ill patient population and this describes the caseload of most teaching hospitals such as Mt. Sinai.

The deciding factor or the clinical consideration which determines into which DRG the case will fall is the principal diagnosis which, for Medicare purposes, has been defined as the medical condition which, after study, was chiefly responsible for occasioning the admission to the hospital. This too gives us cause for concern about the appropriateness of the classification/payment system. The principal diagnosis, defined this way, is not necessarily the most resource intensive diagnosis and does not necessarily bear payment that reflects the level of care actually furnished. If a patient is hospitalized for cataract surgery, a relatively simple procedure today, and has cardiac arrest on the operating table he will be treated for his heart condition before he is sent home, which may involve more major surgery. His principal diagnosis, however, will fall into the DRG case type for ophthalmological lens procedures and the payment the hospital will receive will be sufficient to cover only about two days of inpatient hospital care and an hour in the operating and recovery rooms. The outlier payment adjustment would do little to correct this gross irregularity.

While it is generally true that the DRG prospective payment program provides desirable financial incentives, we must be careful that as a side effect it does not provide undesirable patient care incentives.

TECHNICAL FLAWS

The results of the first year under the prospective payment program highlighted certain technical flaws in the methodology. The relative weights assigned to each DRG which determine the payment amount were developed from data recorded in a year when the codification and sequencing of all diagnoses and procedures was not emphasized for accuracy or completeness on the Medicare billing documents from which it was extracted. Additionally, significant technological innovation has transpired since that year which is not reflected in the payment scheme. For these reasons, we must question the adequacy of the rates computed by applying no longer current and not necessarily comprehensive relative weights.

The price setting formula recognizes the Metropolitan Statistical Area in which the hospital is located and makes adjustment for the level of wages paid, which in Cleveland is significantly higher than the national average. What the formula does not recognize is that inner-city hospitals' costs for labor exceed suburban hospitals' costs within the same MSA. Inner-city hospitals, particularly inner-city teaching hospitals, typically treat a more severely ill patient population which not only requires more staff in terms of absolute numbers of employees, but also requires a more highly skilled and more highly paid staff. Our security forces must be more heavily manned in the inner-city environment, and our physical plants are typically older and require more on-site maintenance crews. Our patients are of a socio-economic background that require more support from social workers and self-help counselors, and lack the support systems at home that would permit us to discharge them earlier in the recovery process.

The Congress recognized that hospitals which treat a disproportionate share of low-income and elderly patients ought to be compensated for the additional costs they are likely to incur in the normal delivery of health care services. The Secretary, however, has so far failed to respond to this Congressional mandate.

For these and a multitude of other reasons, it is difficult for those of us in the hospital industry to accept that any two hospitals are truly comparable. Hospitals within the same MSA do not necessarily have similar missions, do not care for similar patient populations either in terms of their clinical or demographic profiles, and do not share similar environmental risks and hazards. The similarities diminish further throughout a state and throughout a region, and exist only in the most basic general terms when east is compared with west and when north is compared with south.

I cannot tell you specifically why the costs of providing health care to Medicare patients is overwhelmingly higher in the East North Central region in which The

Mt. Sinai Medical Center is located than it is in the South Atlantic region or in the East South Central region. I can tell you that much of the industry that provided jobs in our area, particularly around the Great Lakes, has relocated to the warmer climates south of the Ohio River over the last ten years causing a vast migration of young, fit workers and their families. We can articulate the sterile statistics of population shifts by age category, unemployment rates, numbers of new unemployment claims, mortality rates, crime rates, vehicular accident rates, and so on, until all we are looking at are meaningless actuarial numbers. But the health care industry does not deal in terms of numbers or statistics, it deals in terms of human beings and their needs, however veried, for personal, hands-on, medical care.

As the legislation now stands, all hospitals across the United States will be paid the same relative amount in 1987 for inpatient hospital services furnished to Medicare beneficiaries, regardless of their mission, their geographic location, their demographic environment, or the clinical/medical/social profile of the members of the communities they serve. To us, this will mean the end of a payment system that embodies positive financial incentives and fairly neutral patient care influences and the beginning of a payment system that forces medical decisions on financial considerations alone and rewards "winners" and penalizes "losers" on all the wring criteria. For all its good faith efforts to respond positively and responsibly to the new payment program, The Mt. Sinai Medical Center will become a "loser" to the tune of about $2.1 million in 1986 and $4.3 million in 1987 and each year thereafter.

The continuation of the blending process has the potential of causing even greater population shifts as the health care component of the cost of labor continues to increase for privately insured employers in areas where Medicare payment is insufficient, which will compound the economic crises certain industrialized parts of the nation still face. And worse, it will raise the question of access to necessary health care services and will cause us to reconsider health care as a privilege and not as a basic right, as has been the overwhelmingly popular attitude and expectation of the American public.

We must remind ourselves of the very basic purpose for the establishment of the Medicare program. It was to promise access to and availability of necessary health care services to older Americans regardless of their existing medical conditions and regardless of the limitations of their income. If we are going to renege on that promise in one year from now, then we must recognize and deal with the likely consequences now, and make it known that the Medicare Act has outlived its usefulness and will no longer serve its original purpose.

It is our recommendation instead that we build upon the lessons of year one under the PPS program, remedy the already recognizable flaws and weaknesses in the plan, and postpone the disruption that the next phase of blending national rates into hospital prices will cause in certain areas until we can understand the differences, evaluate the threats, and make responsible and intelligent decisions accordingly.

STATEMENT OF FORMER CONGRESSMAN JAMES ROOSEVELT, CHAIRMAN, NATIONAL COMMITTEE TO PRESERVE SOCIAL SECURITY AND MEDICARE

If the Congress wishes to keep faith with its Medicare commitment made 20 years ago, it will reject the administration's Medicare budget proposals. I urge you to do so as a former Congressman who voted for Medicare and as chairman of the National Committee To Preserve Social Security and Medicare with its 1.2 million members.

The goal of Medicare was to make health care affordable for the elderly. While never fully achieving this goal, Medicare has greatly reduced the out-of-pocket health care costs of our nation's elderly. In recent years, unfortunately, Medicare protection has eroded. In 1984, the elderly spent an average of $1,526 out-of-pocket or 15 percent of their income for health care, the same percentage of their income before Medicare. In 1989 the percentage would be 18 percent—but that is without further cuts.

Skyrocketing health care costs are the prime culprit in this erosion of Medicare protection. But Congress also shares some blame for failing to control health care costs and shifting more costs to the beneficiary. In our view, Congress "blames the victim" when it cuts Medicare benefits, which it has done three times since 1981.

Most of the administration's proposals have been considered before by Congress and rejected. I want to thank Members of the House who have tried to hold the line more so than members of the other chamber. I urge you to continue resisting the temptation to take the easy way out.

The single largest benefit cut in the administration's proposals is to increase the Medicare Part B premium to cover 35% of SMI program costs. If this were adopted as public policy, by 1990 beneficiaries would be paying more than double what they pay now, $408 a year instead of $186.

In addition to the Part B premium amendments, other small proposed cuts set dangerous precedents and add to the bit taken out of the income of Seniors. For example, by indexing the Part B deductible to the physician economic index, one more element of Seniors' out-of-pocket health care costs will go up faster than general inflation. Delaying initial eligibility one month is but the first step in increasing the age for Medicare to 67, an unwise recommendation of the 1982 Advisory Council on Social Security. The proposed home health care co-payments contradict current public policy which has been to encourage home health care rather than more costly institutionalization.

In addition to budget proposals that directly increase out-of-pocket health care costs for Seniors, proposals regarding doctor and hospital reimbursement may also have a negative impact on beneficiaries. The National Committee favors mandatory assignment for doctors who receive reimbursement from the Medicare program. Private practice doctors treating Medicare patients have been the exception to the mandatory Medicare assignment rule for health care providers such as hospitals, hospital-based doctors and Medicare-Medicaid claims. Last year, however, we supported compromise legislation freezing doctor's fees for one year and creating a Medicare participating doectors' program for physicians who accept assignment all the time. As an incentive, Medicare promised participating doctors streamlined billing procedures and updated fees after the fee freeze.

This legislation resulted in a dramatic increase in doctors accepting assignment all the time (from 18 percent to 29 percent) and an increase in the percentage of total bills where doctors accept assignment (from 56 percent to 66 percent). The administration's proposals to freeze *all* doctors' fees another year, however, would undermine the participating physician program, and very likely cause a decrease in the number of participating physicians and the total assignment rate.

We have always argued that Medicare should keep its promises to beneficiaries. We believe Medicare also should keep its promise to participting physicians to update their fees at the end of the 15 month fee freeze period. If Congress extends the freeze, it should strengthen the participating doctors program by exempting participating doctors from the freeze. This will encourage more doctors to accept assignment all the time.

The administration proposes its largest health care budget saving by means of a freeze on hospital reimbursement rates. The National Committee advocates health care cost control to avoid bankruptcy in the Medicare Trust Fund or increases in beneficiary out-of-pocket costs. However, before implementing a freeze on hospital reimbursement rates, this Subcommittee and the Congress should evaluate whether the proposal will adversely affect the quality of health care available to the elderly.

The prospective payment system for cost containment is midway through implementation and hospitals are at different stages of implementation. While initially successful in containing costs, many problems have appeared in the system which require adjustments. Many of our members complain about being denied care as a result of the new prospective payment system. To freeze reimbursement rates, before the program is fully implemented and adjustments have been made, will exacerbate the financial problems of many hospitals and the quality of care problems of Seniors.

In conclusion, we are very disappointed with the administration's budget proposals for Medicare. The proposals would cause substantial increases in out-of-pocket health care costs to Seniors. Even the cost control proposals are seriously flawed with their potential to undermine the participating doctor's program and the quality of health care. It appears to us that these proposals have been put forth to achieve pre-conceived budget targets, but with little concern about their effect on the Medicare insurance program and the beneficiaries this program serves.

STATEMENT OF LOUISE F. SAMUEL, PRESIDENT, NATIONAL FEDERATION OF LICENSED PRACTICAL NURSES

Mr. Chairman and Members of the Health Subcommittee, the National Federation of Licensed Practical Nurses appreciates the opportunity to present our views for inclusion in the record of the Subcommittee's hearings on Medicare budget proposals.

The NFLPN is the national professional association of and for practical and vocational nurses. LP/VNs are the nation's second largest health care profession, and are found in every setting where direct care by licensed nurses is provided.

We are well aware of the critical responsibility of each member of the Subcommittee to act wisely and well to assure that the Medicare program remains fiscally sound, responsive to the needs of its beneficiaries, and supportive of the overall health care system. Because of its sheer size as a major domestic spending program and a major health care payor, Medicare's policies profoundly affect the nation's health delivery system, often in ways not anticipated. Therefore the continuing legislative and oversight role of the Subcommittee is vitally important.

We are also aware Mr. Chairman, that Medicare legislation in 1985 proceeds within the larger context of Federal deficit control, and against the backdrop of the pervasive policy changes of 1983 that created the hospital prospective payment system (PPS).

A purpose of our statement to you is to report that the PPS system is having a very troubling impact on nursing care in many of our nation's hospital. Whether due to actual or anticipated financial impact, hospitals have acted, and in some cases we believe overreacted to the incentive of PPS by reducing nurse staff complements to potentially dangerous levels. Recent widespread reports in the press, including a widely-noted article in the Wall Street Journal of March 27, have documented massive nurse layoffs and identified an increasing phenomenon of nurses who are being overworked, assigned to unfamiliar areas of responsibility, or too many patients, and put at risk of dangerous errors in judgment or misassessment.

At the same time, it has been reported that average hospital operating margins last year improved, even though many rural and inner-city hospitals are in financial trouble.

Mr. Chairman, we do not pretend to be expert health economists, and would not attempt to offer any opinion on complex questions involving health care financing on a national basis. But we cannot but wonder, from the perspective of the bedside, whether the burden of cost containment is falling more heavily at the very place where health care often succeeds or fails. If nursing becomes the weak link, can the chain hold anywhere? We also wonder whether a particular hospital's success in coping with DRGs is as much a function of its geographic location as its relative efficiency.

Other witnesses have pointed to various inequities that are appearing in the DRG transition. Problems are inevitable in so massive a reversal of policy. It is one thing to concede that some problems are unavoidable. It is another to avoid dealing with them, or worse, to propose actions that exacerbate them.

FREEZING HOSPITAL PAYMENTS

NFLPN is opposed to the Administration's proposal to freeze DRG payments to hospitals at current levels through fiscal year 1986. Such an action would introduce further disruption into an already disorderly transition from cost-based to prospective payments, and push some, perhaps many hospitals to dangerous quality levels. Such a change is a breach of faith with hospitals and their patients, and imposes unacceptable burdens on the hospital work force. Moreover, a DRG freeze is an invitation for some hospitals to sweat out further efficiencies from labor costs, the one area DRG advocates viewed from the begining as "controllable". There are some things expensive technology can't do. But no one is talking about firing the machines.

We urge this Subcommittee and the Congress to reject a DRG freeze, and permit a full inflation adjustment in 1986.

TRANSITION STRETCH OUT

NFLPN supports proposals by Rep. Matsui and others providing for a one year extension of the present blending ratio of DRG prices and hospital-specific costs. This pause in the transition to full DRG-based pricing is warranted in order to allow for the application of more appropriate area wage-level adjustments, attention to uncompensated care problems, and other identified inequities.

SKILLED NURSING FACILITY AND HOME HEALTH CARE POLICIES

The incentives for early discharge inherent in PPS, together with the rapid increase in demand for long term care services by a growing elderly population, make it imperative to assure access to quality services in post-hospital settings. LP/VNs are a key component in the continuing of care. More and more members of our profession are working outside of hospitals, and more will be needed in the future as patterns of utilization change in favor of non-acute care. Now does not seem the time to further constrict alternative services through Medicare payment freezes. We suspect that such policies will prove more costly in the long run, by crippling the development of less costly modes of treatment. Even where SNF and home health services are available, adequate nurse staffing must be maintained to assure quality.

ALTERNATE FUNDING OF MEDICARE

The Reagan Administration has consistently advocated a policy of reducing provider payment and increasing out-of-pocket contributions of beneficiaries as the way to control Medicare trust fund outlays. That approach could certainly help keep the program solvent, but it will not make Medicare successful in achieving the purposes for which it was created. If the current payroll tax base for funding Medicare Part A is unreliable, then new revenue sources must be considered.

NFLPN urges the Ways and Means Committee to adopt pending legislative proposals to increase federal excise taxes on tobacco and alcohol products, and earmark these revenues to the Medicare Hospital Insurance Trust Fund. The direct link between Medicare utilization and consumption of these products is undeniable. Therefore it does not seem unfair to ask those who will use Medicare benefits more than others to shoulder a greater responsibility for the cost of those benefits.

CONCLUSION

Mr. Chairman, NFLPN recognizes that a careful balance must be struck between keeping Medicare outlays from returning to the unacceptable growth levels of the late 70's and early 80's, and continuing to assure that needed services are provided. LP/VNs are a large, important, and cost-effective health care resource at the critical point of direct patient care. Medicare must, as its name implies, stand for care.

We urge you to keep this goal before your eyes in the midst of discussion about budget numbers and program statistics. You can count on our support for careful and reasonable policies that will preserve the value of this program for those who, in the final analysis, it was intended to serve.

Statement of the National League for Nursing

The National League for Nursing (NLN) commends you and your Committee for your attention to the subject of clinical education programs for the health professions. The NLN is the accreditation body for nursing education and includes 2,000 agency members and approximately 17,000 individual members. We are writing to share with the Ways and Means Subcommittee on Health the views of our organization and request that these comments be included in the record of your April 15, 1985 hearings.

We are particularly anxious to comment on some of the proposals being discussed publicly and privately to set Medicare's payment for graduate medical education to reflect the number and kinds of physicians being trained in a hospital. We do not wish to address the appropriateness of these proposals for physicians. Rather, we want to underscore our belief that these proposals are not germane to Medicare's policy on nursing clinical education programs. In fact, actions that may be taken with respect to physician education support could have very profound effects on nursing education in the hospital setting, without deliberately intending to do so.

By way of background, it is important to recognize that Medicare payments to teaching hospitals for the direct costs of educational programs include funds for nursing education and the training of many other professions, as well as the costs of graduate medical education (GME). At the time, there are few data available on the proportion of Medicare's payments that is applied to non-physician health professions programs. The NLN is currently conducting a survey of nursing educational programs to gain more precise estimates of the costs of clinical programs in nursing and the contributions made by Medicare. We will share these data with the Committee and other interested parties.

Meanwhile, we do know that the nursing component of overall Medicare educational payments to hospitals is proportionately small. Yet, these funds are critical to the financial viability of many programs. It would be unfortunate, indeed, for these clinical education programs in nursing and the allied health professions to lose or receive reduced Medicare contribution to direct educational costs because of policies designed for and aimed at GME programs. Conditions for future Medicare funding of GME should not apply to nursing education programs.

There is, in our view, not nearly so clear a consensus concerning the adequacy of the supply of registered nurses as there seems to be with respect to physician resource. On the contrary, we believe that in particular specialties and in the case of advance prepared practitioners, there are serious shortages and a maldistribution of nursing manpower. With the dramatically changing health system resulting in more acutely ill hospital patients, an explosion in ambulatory health services, and a growing demand for post-acute and home care, it would be difficult to justify reduction in Medicare's funding of nursing education on the grounds of an oversupply of nurses.

It is also important to note that hospitals with large graduate medical education programs do not always have large nursing education programs, and vice versa. Nursing and physician education programs are developed by different schools and are often operated by separate institutions with different goals and resources. They relate to each other by virtue of sharing the resources and responsibilities of a teaching hospital. Thus, reduced GME Medicare payments to a hospital under some future provision of law could seriously jeopardize a nursing education program opeating in the same institution and the effect on the nursing program would not necessarily have been considered in formulating such policies.

Nursing, like other health professions, is going through a period of profound change adjusting to new trends toward less hospitalization and more ambulatory and primary care. However, the types of changes that are likely and the responsiveness of nursing educational programs to changing consumer demands present a very different picture from those of graduate medical education programs. We would urge, therefore, that separate consideration be given to both the need for nurses and the urgency and form of any government incentives for nursing education under Medicare. Conclusions about what Medicare should pay for physician education in the clinical setting should be separate and distinct from policies that may be developed for nursing programs.

Given these factors, the National League for Nursing urges that you apply your conclusions regarding Medicare payment toward graduate medical education only to those programs involving physicians, and continue to recognize and pass-through the costs of nursing and other health professions programs. If, at some point, your Committee wishes to review the future need for nurses, the types and extent of training that would be appropriate, and Medicare's responsible share of these costs, we would be glad to be of assistance.

RESOLUTION: SUPPORT FOR THE SCHEDULED MEDICARE PPS TRANSITION

We, the undersigned representatives of the hospital industry in our respective states, wish to go on record as supporting the scheduled transition of the Medicare prospective payment system (PPS). We oppose any efforts that would delay the move from the current 50/50 percent level of hospital specific and regional/national prices to the 25/75 percent level of hospital specific and regional/national prices.

We believe that the prospective payment system's design to reorient hospital incentives has been overwhelmingly successful. Full time equivalents (FTEs) are dramatically down from just a year ago. In that same year, lengths of stay have been reduced nationally by over two days. Hospital productivity is at an all time high. The prospective payment system has also fostered long-term financial stability for the Medicare program. Besides saving the federal government billions of dollars, the prospective payment system has benefited third party and private payers, as well as beneficiaries in the Medicaid program.

Fiscal predictability for hospitals was one of the cornerstones of the prospective payment system. Stopping the transition will severly disrupt the necessary fiscal predictability for hospitals, which have responded to the system in good faith. Such a delay will prompt some members of Congress to propose harsh regulatory hospital cost containment legislation which will stifle innovative, cost cutting initiatives already under way. Such action will not overlooked by the States, and punitive state cost containment legislation will proliferate as a result.

We urge you to strongly oppose all efforts to delay the scheduled Medicare prospective payment transition.

Alabama Hospital Association; Arkansas Hospital Association; Louisiana Hospital Association; Mississippi Hospital Association; Hospital Association of New York; Oklahoma Hospital Association; South Carolina Hospital Association; Tennessee Hospital Association; and Texas Hospital Association.

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